DOCUMENT RESUME

ED 175 139 EA 012 049

TITLE	A Planning Study for the Billerica Human Service Center.
INSTITUTION	Boston Coll., Chestnut Hill, Mass.
SPONS AGENCY	Merrimack Education Center, Chelmsford, Mass.
PUB DATE	Feb 79
NOTE	204p.; Document prepared by the Social Work Field Team; Sponsored in part by the Greater Lowell Area Strategy Planning Team
EDRS PRICE	MF01/PC09 Plus Postage.
DESCRIPTORS	*Human Services; *Interagency Cocrdination; *Interagency Planning; *Program Development; *Social Agencies
IDENTIFIERS	*Massachusetts

ABSTRACT

This document discusses the development and implementation of a multiservice center that could offer a variety of human social services in a single location. The paper focuses on seven components of the center's operation: governance, organizational structure, core services, joint funding, joint planning, joint programming, and evaluation. The problem of service integration in a four-town area of Massachusetts was studied via questionnaires sent to member agencies of the strategy planning team. Results indicated the agencies were committed to the proposed multiservice center. A detailed evaluation and synthesis of the survey is provided in conjunction with socio-demographic data and a resource inventory. A final chapter discusses issues of implementation. (Author/LD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED175139

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

A Planning Study for the Billerica Human Service Center

Prepared for:

The Greater Lowell Area
Strategy Planning Team

Prepared by:

The Boston College
Social Work Field Team

Study Sponsor:

Merrimack Education Center
101 Mill Road
Chelmsford, Massachusetts

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

J. Sanders

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

February, 1979

EA 012 049

GREATER LOWELL AREA STRATEGY PLANNING TEAM

AGENCIES AND REPRESENTATIVES

Merrimack Education Center
101 Mill Road
Chelmsford, Massachusetts 01824
Dr. Richard J. Lavin, Chairman, Executive Director
Telephone Number 256-3985

Merrimack Education Center
101 Mill Road
Chelmsford, Massachusetts 01824
Dr. Leslie C. Bernal, Associate Director
Telephone Number 256-3985

Department of Public Welfare
100 Merrimack Street
Lowell, Massachusetts 01852
Ms. Arlene Redmond
Telephone Number 454-8061

Department of Public Welfare
100 Merrimack Street
Lowell, Massachusetts 01852
Mr. Donald Scott
Telephone Number 454-8061

Department of Youth Services
336 Baker Avenue
Concord, Massachusetts 01742
Mr. Walter Hutcheon
Telephone Number 369-8711

Elder Services of Merrimack Valley
420 Common Street
Lawrence, Massachusetts 01840
Ms. Carolyn Hubers
Telephone Number 459-2252

Lowell Public Schools
89 Appleton Street
Lowell, Massachusetts 01852
Dr. Patrick Mogan, Superintendent
Telephone Number 459-7165

Office for Children
224 Worthen Street
Lowell, Massachusetts 01852
Ms. Pat Shearer
Telephone Number 459-2566

Massachusetts Rehabilitation Comm.
24 Merrimack Street
Lowell, Massachusetts 01852
Mr. James Parker
Telephone Number 457-7544

Mass. Commission for the Blind
110 Tremont Street
Boston, Massachusetts 02108
Mr. Peter Sanborn
Telephone Number 727-5590

Solomon Mental Health Center
391 Varnum Avenue
Lowell, Massachusetts 01854
Kenneth Bryant, M.D.
Telephone Number 454-8851

ABSTRACT

In September, 1978, the Lowell Area Strategy Planning Team invited students of the Boston College Graduate School of Social Work's Community Organization/Social Planning Sequence to study the problem of service integration in the four town area of Billerica, Chelmsford, Tewksbury, and Westford. The overall responsibility of the Planning Lab involves the four tasks of developing a socio-demographic profile, develop- a needs assessment, reviewing current models and developing a plan to implement a multi-service center. Through an analysis and systhesis of the data, priorities are identified for a center that include counseling, information and referral, outreach and community education, crisis/family intervention, transportation, and advocacy.

Planning goals and recommendations for implementing a multi-service center are also offered:

(1) To create a pluralist model of governance that includes providers, consumers, and local officials;

(2) To create a collegial model for organizing co-located agencies that offers direct lines of authority for project staff, while agency staff report to their own agency for supervision;

(3) To create shared core services that include common intake, case team diagnosis, referral, and follow-up. An MIS is developed to aid in the provision of these services. As well, a new billing system is instituted which ultimately results in the center becoming the fiscal agent;

(4) To create a mechanism for the joint determination of needs and the assignment of responsibility for new programs to individual agencies;

(5) To create sources for future funding that includes pooled resources, grants, and fees generated through third party payments; and

(6) To create a mechanism for evaluation.

It is also recommended that the ASPT organize the community in order to bring about this radical change in their environment. This must be done immediately if the center is to begin. One must have the full cooperation of all involved to make the center work.

ACKNOWLEDGMENTS

The Boston College Planning Lab would like to express its sincere appreciation to the members of the Lowell Area Strategy Planning Team, with special thanks to Drs. Richard Lavin and Leslie Bernal of the Merrimack Education Center for their supervision and support. In addition, we would like to thank Dr. Frederick Ahearn of Boston College for his patience, supervision and advice.

Last, but not least, we would like to thank Boston College for offering us the opportunity to take part in a true planning experience. It has provided us with a rewarding and invaluable learning process.

* * * * * * * * *

TABLE OF CONTENTS

CHAPTER I INTRODUCTION

CHAPTER II REVIEW OF THE LITERATURE

2.1 Introduction
2.2 Muitiservice Center Concept and its Historical Development
2.3 Social Integration
2.4 Co-location of Services
2.5 Governance
2.6 Community Participation
2.7 Organizational Structure
2.8 Staffing Patterns
2.9 Core Services
2.10 Administrative Linkages
2.11 Management Information System
2.12 Evaluation
2.13 The Brokerage Concept
2.14 Conclusion

CHAPTER III SOCIO-DEMOGRAPHIC PROFILE

3.1 Introduction
3.2 Population
3.3 Age
3.4 Sex Distribution
3.5 Race Distribution
3.6 Spanish Language Population
3.7 Educational Attainment
3.8 Family Structure
3.9 Income and Occupational Status
3.10 Housing
3.11 Welfare
3.12 Conclusion

CHAPTER IV RESOURCE INVENTORY

4.1 Introduction
4.2 Findings
4.3 Conclusions

CHAPTER V SURVEY OF ASPT AGENCIES

5.1 Introduction
5.2 Objectives of the Survey of Agencies

TABLE OF CONTENTS (cont.)

5.3 Methodology
5.4 Findings of Survey
5.5 Conclusion

CHAPTER VI SYNTHESIS, ANALYSIS, AND PLANNING GOALS

6.1 Introduction
6.2 Priorities
6.3 Issues
6.4 Restatement of the Problem
6.5 Planning Goals
6.6 Conclusion

CHAPTER VII THE PLAN

7.1 Introduction
7.2 Governance
7.3 Organizational Structure
7.4 Staffing Patterns
7.5 Core Services
7.6 Planning and Programming
7.7 Funding
7.8 Evaluation
7.9 Conclusion

CHAPTER VIII IMPLEMENTATION ISSUES

8.1 Introduction
8.2 Governance
8.3 Organizational Structure
8.4 Staffing Patterns
8.5 Core Services
8.6 Joint Programming
8.7 Funding
8.8 Evaluation
8.9 Community Acceptance
8.10 Incorporation vs. Lead Agency
8.11 Conclusions

CHAPTER ONE: INTRODUCTION

This document reports the development and implementation of multi-service center which offers a variety of social services in a single location. The paper focuses on seven components for the operation of a multi-service center. These components are defined as follows:

(1) Governance --the group of people that sets policy and is held accountable for the system's operation;

(2) Organizational structure--a method to ensure proper job utilization;

(3) Core services--outreach, diagnostic, referral, monitoring, client advocacy, and follow-up services delivered by the center;

(4) Joint funding--a method of financing that allows for rational allocation of resources and continuous supply of funds;

(5) Joint planning--the structure process that determines total service, delivery needs, and priorities;

(6) Joint programming--a method for developing programmatic solutions to defined problems in relation to existing resources; and

(7) Evaluation--the method for monitoring quality control and analyzing feedback.

Issues associated with each of these components will be examined later in this discussion. A multi-service center offers a satisfactory solution to present delivery system problems. The multi-service center is a means of accomplishing service integration. Integration entails the efficient coordination of services, so that clients can easily obtain needed treatment.

The integration of services has become progressively more important to the Department of Health, Education and Welfare (HEW) over the last decade. In the

mid-1960's the department had limited involvement in the Office of Economic Opportunity's attempts, under the Community Action Program, to link together programs serving the poor. Later, HEW played a coordinative role in the thirteen Neighborhood Services Programs and in the Model Cities Program. In 1971, then Secretary Elliot Richardson, recognizing the need for improved coordination of HEW's own programs at the state and local level, proposed a new legislative initiative aimed at the integration of services, the Allied Services Act.

At the same time, the department began a series of demonstration projects. These Service Integration Targets of Opportunity (SITO) grants tested various service integration techniques, primarily at the delivery level. Under the grants, numerous techniques were developed and demonstrated including new information and referral systems, one-stop service centers, and new case management procedures. These SITO projects were funded for up to three years, with final grants being made in June, 1975.

In 1974, the department initiated a new series of demonstration activities, called Partnership Grants. These grants, expanding on the SITO concept, aimed at building the capacity of state and local governments to carry out comprehensive planning, management, and delivery of human services. The Partnership Grant Program included demonstrations in a total of forty-one different sites.

In addition to sponsorship of service integration activities at the state and local levels, in an effort to establish its own mechanism for improving national planning and management of human services, the U.S. Department of Health, Education and Welfare issued a policy statement outlining the department's plan to "assist chief executives of state and local general purpose governments to improve their capacities to plan and

manage human service programs." Thus, attention was focused on governors, mayors, and county executives as crucial spokesmen and liasons in the promotion of services integration.

Along with emphasizing the need for social service integration, HEW established an internal Capacity Building Policy Council; key department officials together considered the inter-governmental and cross programmatic dimensions of HEW's activities. The Council's primary responsibility was the identification and reform of HEW regulations and operations which impeded state and local efficiency. In addition, HEW was challenged with the responsibility for developing a comprehensive evaluation strategy for services integration.

Influenced by the federal mandate, the Commonwealth of Massachusetts began to look at its service delivery system and management at the local level. Findings reported that throughout the Commonwealth, suffered from problems of inaccessibility, unresponsiveness, and fragmentation. Inaccessible services were described as difficult to approach for a number of reasons, whether it be distance, red tape, or lack of agency visibility. Unresponsiveness involved agency attitudes of unwillingness or inability to meet the needs of the community. It was found that many agencies rely on central (rather than local) planning; specific local needs often go unrecognized. It was also found that fragmented services were delivered in an uncoordinated fashion leading to unnecessary duplication of services and funding inadequacies. Lastly, organizational autonomy was seen as another reason for ineffective service delivery. In attempting to maximize the autonomy of their individual organizations, agency heads were not making use of other community offerings.

Recognizing these problems, Jerald Stevens, Secretary of the Executive Office of Human Services attempted to construct a better method of integrating and coordinating services.

In October of 1976, Secretary Stevens mandated that each state agency link up with other state agencies in their respective areas to improve service delivery through a team approach.

The team approach referred to those agencies that were mandated to participate. Each agency designated one person of their staff as a member of the team. Appointees from various agencies worked together to find ways for providing better service delivery systems. These teams became known as Area Strategy Planning Teams (ASPT)--and a formal and informal communication network among and between agencies was established. Moreover, local planning and management became more feasible than ever before. In accordance with EOHS planning guidelines, the teams held public hearings to assess community needs and from these local requests, proposals were formulated and presented to EOHS for funding.

The Lowell Area Strategy Planning Team (LASPT) was organized in response to the EOHS mandate. The team is composed of appointees from Solomon Mental Health Center, the Department of Youth Services (DYS), the Department of Public Welfare (DPW), the Massachusetts Commission for the Blind (MCB), the Council for Children (CFC), the Massachusetts Rehabilitation Commission (MRC), Elder Services of Merrimack Valley, the Lowell Public Schools, and the Merrimack Education Center (MEC). The team is chaired by a representative of MEC.

Following the EOHS directive, the LASPT initially met in January, 1977 to discuss problem areas within the community. In 1978, after the mandated public hearing was held, the LASPT was able to identify certain problem areas within their service delivery system. First, it was found that services were often fragmented, inefficient, and unresponsive to client needs. Next, accessibility of services was poor; few agencies were located in the Southern tier (towns of Billerica, Tewksbury, Chelmsford, and Westford). As a result of the

public hearings and discussions among LASPT member agencies, then, the team submitted a preliminary proposal that was granted by EOHS.

Subsequently, the LASPT approached Dr. Frederick Ahearn, Chairperson of the Community Organization/Social Planning Sequence of the Boston College Graduate School of Social Work and discussed the possibility of having a planning lab assist the LASPT in designing a multi-service center. This desire became an operational reality and now students of the Boston College Graduate School of Social Work Community Organization/ Social Planning Sequence are participating in a four-day, thirty-two hour field practicum--designed to provide learning and training under qualified supervision in a true planning experience.

Specifically, the LASPT requested that the Planning Lab explore the problem of service integration and design a multi-service center that meets LASPT agencies' needs. The Boston College Planning Lab was expected to gather and analyze data. After interpreting the findings, the team would be responsible for developing a multi-service center plan. The plan would then be offered to the LASPT to serve as a guide for actual implementation.

The responsbility of the Planning Lab involves the following five tasks:

(1) Development of a socio-demographic profile. This is a necessary step in becoming familiar with the overall make-up of the community. What is the population? Racial and ethnic composition? Income? Educational levels?

(2) A needs assessment. This is used to study service needs within the community. It's purpose is to define the requirements that enable the population to function adequately in various life roles. In an effort to identify individual and community goals in relation to the present situation, survey questionnaires were completed by LASPT member agencies.

(3) Review of the literature. (Undertaking a thorough study of multi-service centers, past and present models are discovered and discussed.)

(4) Identification of issues and problems for implementation. (This is done with the aid of needs assessment results in conjunction with literature review).

(5) Development of a plan for an operational multi-service center. (This is accomplished after careful analysis of the four previously stated tasks.)

All tasks will be accomplished in the planning process.

* * * * * * * *

CHAPTER II: REVIEW OF LITERATURE

2.1 Introduction

The following chapter reviews the current literature available regarding multi-service centers. It provides an overview of what a multi-service center is and what types of centers presently exist. The Planning Lab used the information gained from the review of the literature as a reference in designing a model multiservice center for the Southern Tier.

The topics addressed in this chapter include: (1) Overview of the multi-service center concept; (2) Essential elements in the multiservice center; (3) Current models that specify the operation and functioning of a center; (4) Advantages and disadvantages encountered in multi-service centers; and (5) Issues raised by multi-service centers.

The chapter will be divided into the following eleven sections: The multi-service center concept and historical development; Social integration; Co-location; Governance; Community participation, Organizational structure; Staffing patterns; Core services; Administrative linkages; MIS; and Evaluation.

2.2 The Multi-service Center Concept and its Historical Development

Broadly defined, the multi-service center is an organization that offers easy access to a variety of social services in a single location. It is designed to counter such problems as fragmentation, inaccessibility, and unresponsiveness of services by providing integrated, relevant, comprehensive, and coordinated services in a physically accessible setting.

Eight principles of the multi-service concept delineate the basic goals of the

organization: They are:

(1) Decentralization of services and programs to the neighborhood level;
(2) Increased responsiveness to meet the needs of the clients;
(3) Access to programs by co-locating, building reference networks, advocacy, and follow-up;
(4) Coordination in a comprehensive pattern in keeping with the principales of social work and rehabilitation;
(5) A continuum of services;
(6) Sharing of resources by incorporating existing services and creating new services when necessary;
(7) Integration of the core services operation through central intake; and
(8) Direction of services to strike at the root causes of presented social problems (Michael March, 1968).

Following these general principles, multi-service centers vary considerably. Each center must develop a program which best meets the needs of its specified client group. This is not an easy task; the center must be able to adapt to ever-changing social conditions. Policy-makers often have problems designing the 'perfect' program because it is difficult to meet all the demands made by the community.

Considerable debate exists among authors as to the origin of the multi-service center concept. Although they appear to be a product of the Sixties and closely associated with the Johnson Administration's War on Poverty, many writers (or authorities) contend that the multi-service center is a philosophical outgrowth of the Settlement House movement. During the late 19th and 20th century, Settlement houses providing a variety of social services, were established to help recent immigrants in U. S. cities. These settlements adopted a reform orientation and were located in the neighborhoods they were servicing. Their physical proximity aided them in acknowledging the problems of the community and in meeting client needs. Supporters of the settlement houses viewed them as vehicles of social reform. Direct service to members of the social-economic lower class implied increased opportunity and the chance for upward mobility. (See Anderson, 1977)

The settlements, however, ultimately gave way to larger, institutional-type social service agencies. This trend continued until the 1950's when it became apparent that the existing social service delivery system was inadequate in attempting to address such social problems as poverty, unemployment and juvenile delinquency. Subsequently, two pilot projects were initiated which suggested a possible alternative to the existing system. These two projects, the Ford Foundation Grey Area Projects and Mobilization for Youth, later provided the conceptual framework for the development of the multi-service center. They indicated that many social problems were multifaceted, and required involvement of the entire community for resolution. The multi-service center concept offered a feasible plan for providing a wide range of services and wholistic approach to problem solving. It also facilitated coordination and integration among agencies. Moreover, and perhaps most important, the center gave the community a feeling of being part of the solution (Marris and Rein, 1967).

In addition, the findings of these two pilot projects provided the impetus behind the War on Poverty effort. To facilitate reform attempts, the Office for Economic Opportunity was created. Ideologically, the Office sought to attack the root of poverty and racial discrimination by placing agencies directly in the target neighborhoods where they could provide direct service and simultaneously organize local residents to promote social change. Many multi-service centers were created in low-income neighborhoods to fulfill these objectives.

It should be noted that some authors see the development of the multi-service center as a functional equivalent of the "old ward system", and believe it to be an 'attempt to institutionalize many of the services performed by local bosses'. According

to this viewpoint, the multi-service center is a replacement of the neighborhood 'ward healer' and patronage system for obtaining jobs, welfare, and legal advice for the poor (O'Donnell and Sullivan, 1969). From a different perspective, supporters of the multi-service center concept praise the centers as "informal, integrated, personal, courteous, and courageous...as making people feel they belong...as offering instant services... (and) as promoting active participation of neighborhoods in the programs." (O'Donnell and Sullivan, 1969).

Regardless of differences in opinion regarding its origin, it is clear that the multi-service center of the Seventies is a result of a gradual process and it is continually changing in form and function to meet contemporary needs. While neighborhood service centers of the Sixties focused on combining direct service with social action and community development, present day centers are shifting towards a goal of coordinating and integrating services among a variety of agencies, usually within a single location.

The change in focus has been dependent upon social trends. Three contributing factors are: (1) an accelerated movement toward larger organizations; (2) increased attention given to the concept of regionalism; and (3) the economic plight and changing role of the cities. (Johnson, 1975). The U. S. is described as moving toward a "new pluralism"--as a "society of organizations in which every single social task of importance is entrusted to larger institutions". (Drucker, 1969). If this observation is correct, it seems likely that fewer and larger social service agencies will be established in the future, providing generalized services which ignore unique neighborhood social conditions. Indications are that neighborhood multi-service centers will decrease in the near future, and those centers able to survive will have to be meticulously designed, operated, and

evaluated in order to achieve financial support and community acceptance. (Johnson, 1975). Furthermore, the ultimate success of the centers will be contingent upon their accessibility, acceptibility, immediacy, comprehensiveness, integration, and responsiveness (O'Donnell and Sullivan, 1969).

2.3 Social Integration

An extremely important factor in the multi-service center organization is the concept of social service integration. Because numerous social programs and agencies in the late Sixties and early Seventies blossomed, coordination and accessibility of programs became very difficult to achieve. Social integration promised a solution to a disorganized and chaotic situation.

Broadly defined, social service integration means linking together the services of two or more service providers to allow for treatment of an individual's or family's needs in a coordinated and comprehensive manner. More specifically, service integration was defined by Elliot Richardson, former Director of HEW (June 1, 1971), as "a process or strategy for increasing coordination, for rationally allocating resources, and for increasing manageability and accountability of human service delivery systems." Richardson also noted the following objectives of service integration:

(1) Provides a holistic approach to the individual and family;
(2) Coordinates the delivery of services for the greatest benefit to people;
(3) Provides a rational allocation of resources at the local level so as to be responsive to local needs;
(4) Provides a comprehensive, coordinated range of services locally.

In addition, it should be emphasized that the concept of service integration subsumes a variety of approaches (Devils Lake, 1975), including:

(1) Concern with the multiproblem family;

(2) Interest in increasing access and accountability of services through a case manager system;
(3) A client tracking system;
(4) A multi-service center;
(5) Coordination, planning and management of human service programs.

Service integration is accomplished by a variety of techniques. In a study of twelve service integration projects, nine common integrating techniques were identified. They are:

(1) Co-location of services;
(2) Shared core service functions;
(3) Mechanisms for information and referral and follow-up;
(4) Agreements to provide complementary services;
(5) Joint funding;
(6) Target group advocacy;
(7) Non-categorical program administration (for those projects both administered and operated by an umbrella agency);
(8) Coordinated program planning; and
(9) Leadership role for general purpose government.

There are a number of factors facilitating service integration. An analysis of four projects (Eastern Central Kansas Mental Health Center, Bethelehem Community Education Project, Brooklyn Family Reception Center, and Atlanta Rehabilitation Center) identified the six factors conducive to facilitating service integration as:

(1) Stable, adequate funding;
(2) Strong project director who is able to mobilize resources, merge conflicting opinions and/or groups, plan effectively, and relate to a broad cross-section of community residents, leaders, and service providers;
(3) Community receptivity to the need for services and a desire to effectively deliver services through an integrated mechanism;
(4) An administrative structure which allows an individual (director) or group (board) to plan and implement programs;
(5) A staff which exhibits a strong desire to increase service delivery effectiveness through service integration; and
(6) Long term planning which considers project goals or purpose, methods to integrate service delivery (e.g., case conference, single funding source, etc.) and current and future funding sources.

Service integration is often difficult to achieve. Studies warn that "if integration is to exist, it cannot only take place within the confines of the physical structures of the center. Planning organized only in terms of the agencies housed in the center would tend to be limited and fragmentary and not attuned to the concept or regionalization." (Arkansas, 1972).

A study of over thirty nationwide service integration projects revealed that service integration has a "positive impact on accessibility, continuity, and efficiency of service delivery to clients. However, the direct economics achieved through integration did not appear to outweigh the cost of achieving integration." (Kahn, Kaplan, Gans, 1972).

2.4 Co-location of Services

Co-location of services refers to the placement of a number of service delivery agencies in a single facility having a common reception area, and sometimes a common intake. Co-location of agencies has the potential for increasing service integration; yet co-location, by itself, does not serve to integrate services. It is also necessary to have power and authority at the administrative level. Many agencies have found that co-location has enabled previously obscure problems to surface, because they are no longer hidden by service fragmentation. (U.S. DHEW, 1974).

A study by a Montana human resource center (Dewitt, 1974) pointed out some pros and cons regarding co-location of services. Noted disadvantages included:

(1) Loss of individual autonomy;
(2) Negative experience with one agency may be transferred to all agencies;
(3) Need for special arrangements when work hours do not coincide;

(4) Need for increased precautions in regard to confidentiality;
(5) Individual problems and conflicts in one agency may affect overall center morale;
(6) Increased access and use of center facilities increases security problems;
(7) Without independent ownership, several leases, agreements, etc. need to be signed.

Identified advantages were:

(1) Cost savings through use of common reception area, waiting room, conference room, etc.;
(2) Easier to arrange cross agency training;
(3) Coordination of travel between all agencies providing field services is possible and is a cost saving factor;
(4) Use of common brochure and public relations activity is possible;
(5) Variety of services in one area save client's time and facilitates more rapid referral when client requires more than one service;
(6) Staff interaction and familiarity can contribute toward activities that reflect common goals and efforts.

2.5 Governance

Governance is the policy making board to which the operating system is directly accountable. In legitimate fashion, it represents the interests of community members. (Baker, 1975).

Governance encourages community support and consensus building through social integration. It also fosters harmony on the state, local, and consumer agency levels. Governance tasks involve determining: (1) the needs of the community; (2) the costs involved in delivering needed services; and (3) the constraints or side effects of the system. (Kane, 1975).

The primary responsibilities of governance involve:

(1) Securing funds and being accountable for them;
(2) Specifying goals of the system in relation to community needs;
(3) Approving operating costs of the system;

(4) Conducting community audits;
(5) Evaluating system effectiveness;
(6) Contracting with the systems manager, and making him accountable for the system.

Governance does not deal directly with the day-to-day operation of the center. Daily management is left to the systems manager. When governance does become involved in this area, it loses the capacity to perform its basic function to provide direction and motivation to the system. (Kane, 1975).

The composition of a governance board is very important. Ideally, a board that is composed of a broad representation of community members (consumers, local officials, and providers) is best able to recognize and meet the needs of the community. Thereby, governance is able to bridge the communication gap between the community and the agency.

The boards that are most likely to have difficulties recognizing community needs are those predominantly composed of, or dominated by, service providers and agency heads. (Blossom Hill Model, 1975). While such members demonstrate a clear working knowledge of the service system, serious problems are likely to be encountered, including:

(1) the inability to speak effectively for the consumer when there is inadequate community representation on the board; and
(2) a tendency to lower expectations of the agency's potential for service delivery by people who are fully imbedded in the system.

Both factors contribute to lessening motivation and thereby decreasing system productivity. (It should also be mentioned that boards totally comprised of or dominated by consumers also have major disadvantages. Although they are supposed to represent the community as a whole, they tend to become self-serving.) (Dewitt, 1975).

2.6 Community Participation

Community participation in the development and operation of a multi-purpose center plays a decisive role in its success or failure. Studies show that in order to be successful, centers must enlist the support of local residents and community leaders. To insure active community participation, it is necessary that strong relationships among staff, community groups, and other key resources at the substate level be established during the preliminary planning phases. (Kane, 1975).

Those centers that do fail are those that have not incorporated community participation during the pre-implementation stages. Examples are, two agencies in Montana and Oregon that neglected to involve the community during the initial planning stages. They found it necessary to expend large amounts of project resources in a final effort to overcome resistance--both among the community and among the participating service providers.

2.7 Organizational Structure

Because limits are imposed by a continuous shortage of personnel at the center, an organizational structure which assures proper job utilization is particularly important. The most prevalent model for human service agencies is based upon a centralized administrative structure. (Organizational/Operational Model for Multi-Service Centers 1975)

The centralized administrative framework (heirachical) is a product of the Industrial Revolution and possesses several distinguishing characteristics, most notably:

(1) A division of labor which engenders job specialization and fosters expertise;
(2) A rational decision-making process in which each person is directly responsible to a superior (direct lines of authority);

(3) Clearly defined rules and regulations which foster predictable behavior;
(4) Uninterrupted production and coordination of activities promoted by selection promotion and remuneration; and
(5) Formalized channels of communication which maintain status and role.

This framework is noted for its mechanical view of organizations. The main elements of emphasis in the structure are discipline, specialization, authority, and unit measures of work. When lines of authority become unclear, the following problems frequently occur:

(1) Improper job utilization;
(2) Lack of accountability;
(3) Lack of interagency coordination;
(4) Lack of integration.

An alternative to the Organizational/Operation Model is a collegial structure. This model is characterized by the equal sharing of power, and a recognition of equal status among participating agencies. The rationale for implementing this model in a multi-service center is that it maintains agency autonomy, minimizes turf issues, and provides supervision for staff at a parent agency. It also provides for specialization among agencies.

The issues involved in the collegial model include:

(1) Conflicting professional ideologies;
(2) Staff conflicts;
(3) Specialization.

Problems in both models occur. While the centralized structure demands a loss of individual agency autonomy and raises turf issues, the collegial model creates conflicts around professional ideologies with each agency vying for the dominant position. In the collegial model, conflicts are less easily resolved because there are no clear lines of authority.

2.8 Staffing Patterns

In a multi-service center two basic levels of staff exist---the direct and core service personnel and the administrative personnel. The function of each is determined by the overall purpose and objectives of the center. Specifically, the roles of the direct service personnel are defined by the task to be performed; the roles of the administrator are a direct reflection of the organizational structure and the degree of authority given to the director.

All centers have a director. The variable lies in the power of the director. Some directors have mediating authority; others have direct authority. In addition, most centers have a "core service" staff that provides the following indirect services: outreach, intake, diagnosis, referral, monitoring, advocacy, and follow-up. In some centers, a case manager performs all of these functions; in others, each function is designated to an individual staff person.

In determining the appropriate functions of personnel in a multi-service center, the major concern is to provide a system in which coordination at the top is effective enough to achieve the highest utilization and most efficient functioning of the staff. (Operational/Organizational Model for Multi-Service Centers, 1975).

2.9 Core Services

Core services represent a method of service integration. They facilitate accessibility, continuity, efficiency, integration, and coordination. Core services include the following: outreach, intake, diagnosis, referral, monitoring, client advocacy, and follow-up.

These services promote integration through the following basic functions:

(1) Outreach is a technique for making social services more accessible to clients in need of service. It is an organized effort to actively seek clients and bring them into the service system. At the same time it educates the community to the services available through door-to-door canvassing, leaflet distribution, posters, etc.

(2) Common intake is defined as a single point of entry into the service system. It directly effects accessibility and continuity of services. It opens up a wide range of services for the client by reducing 'red tape', by minimizing waiting time, and by removing most barriers hindering client movement through the system. It effects continuity through specification and clarification of eligibility requirements at the time of entry. Also, a common intake system avoids duplication and repetition of services.

(3) Diagnosis is the function which assesses the client's needs for the purpose of developing a service or treatment plan. Continuity is increased if the service plan which is developed offers simultaneous rather than consecutive service delivery.

(4) Referral is the process of directing and linking clients to an appropriate agency to receive the needed services. At the same time, referral increases client's awareness of the availability of services. It also allows clients to form direct relationships with other service providers, which makes future service provision easier. A joint referral system enhances efficiency by eliminating need for duplication of service.

(5) Monitoring is a method of tracking the client through the system and insuring that the service plans are being met. It increases continuity by maximizing the ease with which a client moves through the system.

(6) Client advocacy is necessary when a client is not receiving specific services to which she/he is entitled. The advocate speaks for the client to insure that proper services are delivered.

(7) Follow-up is the final step of core service provision, and occurs upon completion of the treatment plan. It evaluates client satisfaction (with the services received) and insures that all needs have been met. In relation to the center's operation, follow-up also provides a check on allocation of time and money thus insuring optimum expenditure of effort.

Among existing multi-service centers, the provision of core services is accomplished in many ways. With variations, however, there are two basic models of core services in the multi-service center (Roessler and March, 1975) which should be examined.

Model A

Two distinguishing features of this are: (1) a central point of entry into the system (common intake) and, (2) an "in house" case management function. While the literature describes three variations of the above model, in all cases, client entry into the system is always the same. Upon entering the center, the client is initially screened by an intake specialist who determines service needs and eligibility. The single problem client is directly referred to an appropriate agency for service treatment. The client with multiple problems is serviced in one of the following ways:

(1) A case manager is assigned to handle the client and assumes responsibility for diagnosis and evaluation. A service treatment plan is written. Then, the case manager is responsible for referring the client to the appropriate agencies, monitoring the client's pathways, advocating for the client (if necessary) and following-up after service delivery. Although this method is time efficient, it places a great deal of responsibility on the case manager. The disadvantage here is that in certain circumstances it tends to raise turf issues in terms of an agency's compliance with the manager's treatment plan (Glasgow, 1974; Devil's Lake, 1975; Utah, 1974; Brockton, 1975).

(2) A case team, composed of representatives from all participating agencies takes responsibility for all diagnosis and evaluation. A treatment plan is agreed upon and all referrals are made at the case conference with each represented agency agreeing to provide certain services. Usually, one agency delivers most of the services, and it is designated as the "lead agency". The lead agency is then responsible for monitoring, advocacy, and follow-up (Waianae-Nanhuli, 1974).

(3) A combination of case manager and case team approach is sometimes utilized. In such cases, the case manager handles most of the central diagnosis and evaluation, and then calls the case team together for consultation and development of a treatment plan; referrals are also arranged. The case manager becomes the team coordinator and is responsible for monitoring, advocacy, and follow-up (Indianapolis, 1976; U. S. DHEW, 1974).

In terms of service integration, using the case team approach (2 and 3) has certain advantages. As team members meet formally to complete their work, informal integration results with getting to know one another and sharing experiences. Each team member introduces his/her own form of expertise. The problems that often arise using this approach regard time and attendance. To ensure success, assurances must be given that each agency will send a representative and allocate time for participation in case team meetings.

Model B

This model is based upon the lead agency concept. With this approach, initial intake is done at each individual agency. By this method of intake, the client becomes able to gain access to all services provided at the center. The multi-problem client is evaluated by the lead agency, and a treatment plan is developed. The lead agency provides its service specialities and then refers the client to the center for help in other areas. The lead agency sends all intake information to central intake at the center, where it becomes available to the center case manager or case team. (Roessler and March, 1975). The case manager arranges referrals (as necessary) by meeting with the team.

This model generally works well, except when agencies fail to send intake information to the center; this creates duplication of effort. Also, it should be noted

that in this model, case teams are usually ad hoc, and not always available for consultation.

Common issues that arise in both Model A and Model B focus primarily on central intake. Problems of confidentiality and information-sharing are inherent in a common intake system and not easily resolved. Also, the level of skill of the intake person is crucial in determining the level of screening accomplished.

2.10 Administrative Linkages

Joint Funding and Joint Programming and Planning will be discussed in this section.

A. Joint funding provides one means of integrating a human service system. It allows for a rational allocation of resources and a continuous supply of funds. Once 'seed money' is depleted and an agency is faced with the uncertainty of future funds, many problems, such as low staff morale and lack of motivation for future planning often arise. Exploring the availability of new funds through local, state, and federal sources, as well as private insurances, then becomes the main focus of the agency.

Once funding is secured, choosing a method for funneling the funds becomes a major issue. Three possible methods are feasible:

(1) Using a single lead agency as a conduit provides one method. (Devil's Lake, 1975). A collaboration is formed in which all agencies sign off on a grant. A lead agency becomes the grantee and is accountable to the funders. The collaborating agencies then contract with the lead agency regarding services to be provided and accounting procedures. Thus, direct authority is given to one source. This may lead to problems such as restrictions in the use of funds. Also, the rules and guidelines that govern the lead agencies' use of funds limits its ways of distributing those funds. If agencies wish to sweeten their pots, though, they can be forced to show an interest in integration and duplication of services is avoided, since one agency controls the money, determining what programs will be established.

(2) Another method is to use the governing board as a conduit for funds. (Brockton, 1975). This allows the center to have direct control over the funds. A steering or funding committee is established, composed of members from the participatory agencies; this allows for joint funding and commitment.

(3) Still another method is to pool resources consisting of public and private funding sources. A case manager then uses these funds to purchase services with the consent of the client. This system effectively documents gaps and weaknesses in service, and also promotes quality and improvements by fostering competition. Unfortunately, a very complex and expensive accounting system arises because of categorical limitations on the spending of these donations.

The federal government contributes to the problems just discussed. Frequently, federal funding is based upon categorical needs, and the money allocated for a specific program can only be used for that program. Waivers, which would allow a transfer of funds from one program budget to another, can be obtained from HEW, but it is a lengthy and time consuming process. Funding, therefore, tends to reflect federally determined needs rather than local community needs.

B. Joint planning is the determinator of total service delivery needs and priorities through a structural process. Joint programming is the joint development of programmatic solutions to the defined problems in relation to existing resources. Joint programming usually arises in response to needs and priorities during the joint planning process. Both help to avoid duplication and ensure appropriate allocation of resources. Together, they also assist in achieving a coordinated and comprehensive service delivery system.

Single individuals or committees are used to perform the task of joint planning and programming. The director or coordinator develops plans and programs which are presented to a committee, usually the governing board. The committee then

revises, approves, or disapproves the plan and/or programs.

Committee or task forces can also plan programs and identify needs. (Waianae-Nanhuli, 1974) Committee members usually consist of participatory agency personnel and other local outside interest groups. These people talk to staff and agency personnel and verify needs so that appropriate plans can be initiated. Outside agencies must be concerned with planning because planning organized only in terms of center agencies leads to fragmentation and a non-integrated conceptual way of thinking. All agencies must be accounted for in a truly integrated system. (Arkansas, 1973).

Task forces can be set up to address a variety of problem areas or interests, such as adolescents, the mentally retarded, or unemployment. The task for each group is to plan and program for its specified target area. Their recommendations are brought to the policy or governing board for approval/disapproval. The more segments of society brought into the planning process, the smoother the integration of services and the planning of programs become.

Problems arise concerning coterminous catchment areas (Blossom Hill, 1975). Coordinated planning becomes virtually impossible if separate agencies serve different areas. (Dewitt, 1977). Other times, joint planning threatens the integrity of programs and budgets. This becomes most apparent when one agency has more resources than the other. Duplication and quality issues may arise and this threatens agency turf as well.

Solutions, however, are available. One is the strengthening of communication lines between neighborhood groups and city government via an advisory committee. (Arkansas, 1973). Another is exercising line authority over center personnel. A final and effective solution is limiting initial interagency efforts at joint programming for

for new programs; (Dewitt, 1977)--this avoids turf issues and allows for a mutually beneficial outcome.

In order to plan and develop a good program, an integrated information system becomes a necessity. A problem that often arises in joint planning is that information necessary for the planning task is confidential and not readily available to the planner. Information can, however, be gathered through a 'need to know' which can circumvent some of the difficulties. Certainly, planning becomes a mere "guessing game" without appropriate and current data.

2.11 Management Information System

The Management Information System (MIS) is essentially a record-keeping system which provides information on clients served, services provided, and payments made. It is also an effective tool in the service delivery system since it is used in both day-to-day support of local operations, and centralized administrative support, management control, and evaluation of programs. (Spencer, 1973).

The rationale for an MIS is that it minimizes duplication of services, improves effectiveness of agency operation, and increases the integration, coordination, availability, and accessibility of services. An efficient and accessible information system is essential to the optimal functioning of a coordinated multiservice center. (Nelson, 1974).

The functional task of MIS is to:

(1) Determine the quality of services being provided;
(2) Monitor the current deployment of resources throughout the organization;
(3) Identify beneficiaries of services;

(4) Provide a foundation for later evaluation of quality;
(5) Assist short/intermediate term program planning;
(6) Provide a foundation for later evaluation of quality;
(7) Assist cost accountability, rate setting, budgeting, and billing;
(8) Assist in coordinating and integrating separate organizational units.

The MIS addresses itself to the following major issues in the delivery of services:

(1) The availability of services within a given area;
(2) Gaps in the delivery of services;
(3) Cost accountability for these services. (Kane County, 1976)

2.12 Evaluation

By definition, evaluation is the process by which results of programs and analyzation of the extent to which they have accomplished predetermined goals and objectives is determined. (National Institute of Mental Health, 1976). Evaluation is an essential component of a multi-service center. It is important to develop and evaluate design in the initial stages of the center's development and it is equally important to consider evaluation as an ongoing process throughout the duration of the center's activities. The center's goals and objectives must be formulated in a specific and a precise manner so that measurement and evaluation of achievement is allowed. For each of the center's goals, it is helpful to develop 'standards' which indicate the desired level of achievement, as well as 'criteria' which will provide measurement of the extent to which the 'standards' are met. (Blossom Hill, 1970).

Evaluation provides a basis for decision making; which programs should be expanded, developed, or eliminated? Evaluation provides such guidelines in two ways: (1) It provides information which consists of monitoring ongoing program activities; and (2) It provides a way of assesing whether the program has attained its stated objectives. Baumheier states, " Policy and program decisions ultimately must

be based on knowledge about the success or failure in the achievement of desired alternatives. It serves an important function in designing, planning, and implementing human services". (1974).

One basic concern of evaluation is program effectiveness. In order to measure effectiveness, an evaluator must assess two factors: accessibility of the system and quality of service delivery. As regards effectiveness evaluation, a common criticism is that there is often too much time and effort put into the 'process of integration' and too little time devoted to the 'effects of integration'. Integration projects should have an incentive to document their impact, because this is important to continued support and funding, as well as providing feedback to managers for future improvements. (Henton, 1974).

Efforts to gain information related to program effectiveness involve choices concerning:

(1) Effects to be measured. This is related to development of indices to measure the goals and objectives of the program. Process objectives may include: bringing together service providers, establishing lines of communication and cooperation, creating integrative linkages, involving citizens, etc. Evaluation must measure the effect these process goals have on the client in terms of accessibility to the network, continuity and increase in adequacy of services.

(2) Evaluation design. It is important to structure an evaluation design with at least two types of comparison to show if any changes have occurred as a direct result of the intervention of the program. The first must compare changes in service delivery, and the second must compare information between sites where intervention has and has not taken place. In order to determine the impact of the project, it is helpful to begin with baseline information; this gives the evaluator an accurate idea of existing conditions before the intervention.

(3) Methods for collecting data. A decision must be made as to how and/or researcher will collect data for program evaluation. Possibilities include: statistics, records, surveys, interviews, etc. (Henton, 1974).

Another concern of evaluation is program efficiency. This is related to the cost/benefit factors in service integration. It is essential in the process of determining program operating costs and allocating costs among agencies. Also, it is specifically related to manpower utilization issues.

A common complaint among service providers is that the emphasis on cost/benefit analysis is often detrimental to service quality. A balance between savings and maintaining a high level of quality is seen as a responsibility of the evaluator. (Marck, 1974).

In summary then, there are five major barriers to program evaluation: (Baumheier, 1974)

(1) Program objectives and goals frequently are not specified in terms conducive to evaluation;
(2) Impact or output measures will have to deal with intangibles and often criteria have no direct empirical referent or relationship to overall system objectives;
(3) It is a problem to develop valid and reliable measurements because they often relate to attitudinal changes in the target group, when the true objective is to encourage behavioral change;
(4) It is difficult to specify the amount of impact a program must exhibit before goal attainment is considered to be achieved;
(5) It is difficult to specify target groups for some programs. Often it is necessary to identify and isolate extraneous factors which enter into the equation of program effectiveness (such as, general state of the economy, unique features of local environment, socio-political environment).

2.13 The Brokerage Concept

This is based on the concept of a free market exchange. This concept states that services can best be provided when agencies compete for money. In this

instance, the clients represent money. With agencies thus competing for clients, treatment offered must be of higher quality and at more reasonable cost than one's competitors.

Clients entering the system come with many known or unknown financial and eligibility entitlements. Entitlements are those resources that do not include personal resources. They might include private health plans or Medicaid. A system that can determine all entitlements and make them known to families benefits clients. Subsequently, then, the more entitlements recognized by the center, the greater the competition among agencies, theoretically creating better services for clients.

Additional financial resources can become available to clients with agencies pooling parts of their budgets and clients themselves using personal or family resources. These, along with entitlements, can successfully be used to the client's advantage.

The client needs a broker who knows the service system. A broker is given the responsibility of handling client and obtaining the necessary services. The broker knows what is available in terms of cost and quality and with the additional knowledge of client eligibility is able to analyze the agency which can best serve the client.

Since the broker controls a large number of resources, service providers must be responsive to broker demands. The broker represents client demands, making social services more sensitive to local demands. Agencies no longer must depend entirely on grant monies for determining what programs they can provide. Money becomes available through individual entitlements, pooled state agency resources, and client resources. Thus the client becomes the program determinant--the service integrator and coordinator.

These assumptions provide a foundation for the design of a multi-service center and allow the center to become the mechanism for service integration.

2.14 Conclusion

After reviewing the literature, it becomes evident that a variety of models is available for multi-service centers. Each model presents certain advantages and disadvantages, as well as raising issues in implementation. In the final analysis, the model chosen by the planner for a specific community must take into account the unique social characteristics of that community. Keeping this in mind, the following chapter presents a socio-demographic profile of the Southern Tier. The profile provides a firm basis for developing an effective multi-service center.

* * * * * * *

REFERENCES

Anderson, Wayne, Bernard Frieden and Michael Murphy, Managing Human Services, Washington, D. C.: International City Management Association, 1977.

Arkansas University Graduate School of Social Work, An Evaluation to Determine the Effects of Coordination, Administration, and Delivery of Service by a ETC, Fayetteville, Ark.: Arkansas University Graduate School of Social Work, 1973.

Baker, Michael in The Design of Human Service Systems, ed. The Human Ecology Institute (THEI), Wellesley: THEI, 1975.

Baumheier, Edward C., "A Summary Statement of Effectiveness of Evaluation in the Field of Human Services," Toward Integrated Human Services: Proceedings of the Services Integration Capacity Building Conferences, San Francisco: Department of Health, Education, and Welfare, 1974.

Denver University, Devils Lake Comprehensive Human Services Center, Denver: Denver University Center for Social Research and Development, March, 1975.

Dewitt, John, Service Integration Elements in Glasgow, Montana Social Service Agency, Denver: Denver University Center for Social Research and Development, September, 1974.

An Evaluation of the Waianae-Nanhuli Human Service Center, Volume III, Honolulu: Statistical Analysis Service Integration Targets of Opportunity Project, July 15, 1974.

Gans, S. and G. Horton, Integration of Human Services, New York: Praeger Publishers, 1975.

Gilbert, Neil and Harry Specht, Dimensions of Social Welfare Policy, Englewood Cliffs: Prentice-Hall, Inc., 1974.

Henton, Douglas, "Evaluating the Effectiveness of Services Integration," Toward Integrated Human Services: Proceedings of the Services Integration Capacity Building Conferences, San Francisco: U. S. DHEW, Nov., 1974.

The Human Ecology Institute (THEI), The Design of Human Service Systems, Wellesley: THEI, 1975.

Indianapolis Department of Metropolitan Development, Organization/Operations Model for Multi-Service Centers, A Study of the Unified Planning, Indianapolis: Department of Metropolitan Development, 1975.

Jensen, Thomas, The Devils Lake Human Service Center Final Report: Human Service Integration Project, Bismark: North Dakota, Social Service Board, June 30, 1975.

Johnson, Harold R. "Neighborhood Services," The Encyclopedia of Social Work, 1972.

Kahn, Alfred, Social Policy and Social Services, New York: Random House, 1973.

Kane, Martin, Brockton Multi-Service Center. Governance Manual Methods of Building and Maintaining, etc., Brockton: Brockton Area Human Resources Group, Inc., June 1975.

Kaplan, Kahn and Gans, Integration of Human Services in HEW: An Evaluation of Service Integration Projects, 1972.

Los Angeles County Neighborhood Service Centers 74-1 Report, Los Angeles: Los Angeles County Board of Supervisors, 1974.

Mack, Greta, "Evaluation Summary Statement," Toward Integrated Human Services: Proceedings of the Services Integration Capacity Building Conferences, San Francisco: U. S. DHEW, Nov., 1974.

March, Michael, PH.D., "The Neighborhood Center Concept," Public Welfare, 26: 23, 1968, pp. 97-112

Marris, Peter and Martin Rein, Dilemma of Social Reform: Poverty and Community Action in the United States, New York: Atherton, 1977.

Mogulof, Melvin B., "Neighborhood Service Centers," Encyclopedia of Social Work, 1975, pp. 859, 865.

Mrozek, Don, Information Collection and Flow of all Agencies at the Albina Multi-Service Center, Portland, Oregon, Salem: Oregon Department of Human Resources, Dec., 1972.

Narrative Client Pathway, Arizona Department of Economic Security, Casa Grande District V, 1974.

Newman E., and J. Turue, "The Crisis of Accountability," Social Work, 19 Jan. 1974

O'Donnell Edward and Margaret Sullivan, "Service Delivery and Social Action Through the Neighborhood Center: A Review of the Research," Welfare in Review, 7:, 6, 1969, pp. 1-12.

Roessler, Richard, Strategies for Inter-Agency Linkages: A Literature Review, Fayetteville; Arkansas Rehabilitation Research and Training Center, Nov. 1975.

Santa Clara County Executive's Office, Blossom Hill Report, San Jose: Santa Clara County Executive Office, July, 1975.

U. S. DHEW, Toward Integrated Human Services: Proceedings of the Services Integration Capacity Building Conference, San Francisco: Nov., 1974.

Utah Department of Social Services, Evaluation of the Integration Project, District V, Phase I, Salt Lake City: Utah Department of Social Services, 1974.

White, Orion F., Jr., "The Dialectical Organization: An Alternative to Bureaucracy" Public Administration Review, 29:1 January/February, 1969.

CHAPTER III: SOCIO-DEMOGRAPHIC PROFILE

3.1 Introduction

This chapter presents a socio-demographic profile of Chelmsford, Westford, Billerica, and Tewksbury. These four towns form the southern tier of the Northern Middlesex Region. The Northern Middlesex Region, as delineated by the North Middlesex Area Commission, consists of Dracut, Dunstable, Billerica, Tewksbury, Tyngsborough, Lowell, Pepperell, Westford, and Chelmsford. The Southern Tier is also part of the Lowell Standard Metropolitan Statistical Area (SMSA) The SMSA consists of seven of the above nine towns, excluding Dunstable and Pepperell.

Routes 128, 3, and I-93 offer reasonable accessibility to Boston from this area. The four towns are residentially oriented and could be considered suburbs of Boston as well as Lowell. Westford is still at the transitional stage between suburban and rural development. For the most part, these towns have low density residential development and small amounts of open space and recreational land. Most of the low density industrial and commercial development that has taken place in the Northern Middlesex area has occurred in these four towns.

3.2 Population

According to the United States Census, the population of the Southern Tier in 1970 was 96,203 or 43.7% of the population of the Northern Middlesex Region. Billerica contained the largest percentage of the area's residents, with Chelmsford and Westford have the least.

Table 3.1 shows the population by town and the percent of change from 1970-1975. The U. S. Census Data of 1975 shows that all the Southern Tier has increased in

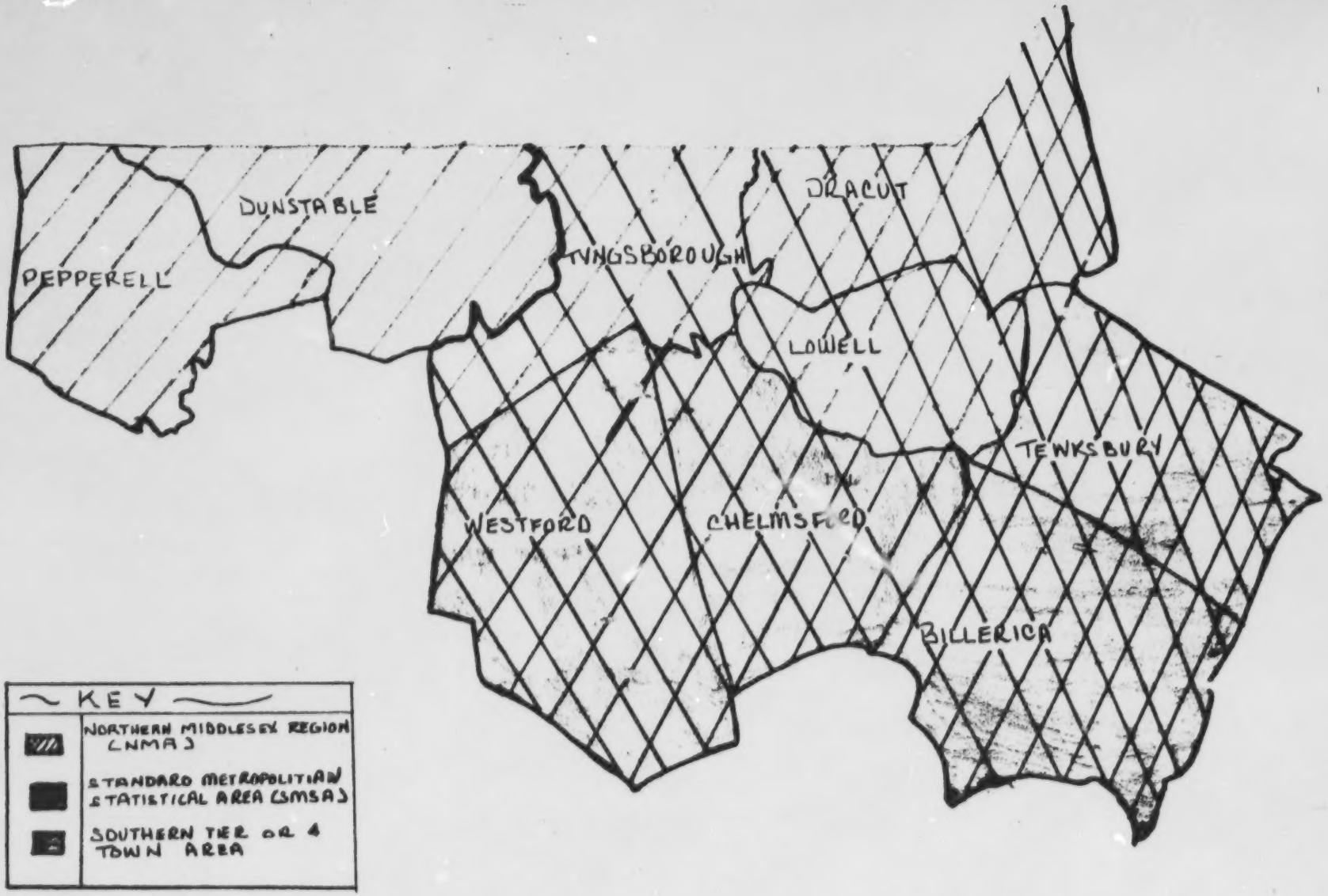

DUNSTABLE
PEPPERELL
TYNGSBOROUGH
DRACUT
LOWELL
TEWKSBURY
WESTFORD
CHELMSFORD
BILLERICA
KEY
NORTHERN MIDDLESEX REGION (NMA)
STANDARD METROPOLITIAN STATISTICAL AREA (SMSA)
SOUTHERN TIER OR 4 TOWN AREA

Table 3.1 Population by Town, and Percentage of Change 1970-1975

City	Number 1970	1975	% Change 1970-1975
Billerica	31,648	35,831	13.2
Chelmsford	31,432	31,749	1.0
Tewksbury	22,755	24,048	5.7
Westford	10,368	12,741	8.4
Massachusetts	5,706,000	5,789,478	.3

Source: 1970 United States Census, and 1975 State Census

population with the highest percentage of change occurring in Westford and the lowest in Chelmsford. The Northern Middlesex Area Commission projected a 6.9% increase for the entire Northern Middlesex Region during the same five year period. Table 3.2 shows that Billerica and Westford grew beyond the projected rate while Chelmsford and Tewksbury grew below it. It is interesting to note that while the Commonwealth (as a whole) grew by only .3%, the Southern Tier increased its population by 8.9% from 1970-1975.

Future projections reveal that, overall, the Southern Tier is going to increase its population by 22.9% from 1970-1990 as compared to a 17.3% increase for the total Northern Middlesex Region. Westford shows the highest percentage increase (53.1%) while Billerica has the lowest (15.6%). (See Table 3.2).

The Chelmsford, Westford, Billerica, and Tewksbury area averaged 1020 people per square mile in 1970; the Commonwealth of Massachusetts in 1976 reported a density of 742.3 persons per square mile. Of the four towns, Chelmsford is the most dense, with 1394 persons per square mile; Westford is least dense with 343 persons per square mile. Both towns are expected to experience future growth, with Westford population at a faster rate.

3.3 Age

As is shown in Table 3.3, the Southern Tier generally has a younger population than the region as a whole. The 5-19 age bracket is 3% higher for the four towns than for the entire SMSA (34% vs. 31.2%). The percentage of elderly in the Southern Tier is 8.1% as compared to 12% for the Lowell SMSA: 11.2% for Massachusetts: 10.7% for New England: and 9.9% for the United States. The largest percentage of elderly

Table 3.2 Area Population Projections by Town, 1980 to 1990

City	1980 No.	1980 %	1985 No.	1985 %	1990 No.	1990 %
Billerica	40,204	34.6	43,332	33.5	46,459	32.6
Chelmsford	33,707	29.0	36,608	28.3	39,509	27.7
Tewksbury	27,266	23.5	30,548	23.6	33,830	23.7
Westford	14,926	12.9	18,890	14.6	22,854	16.0
Total	116,103	100%	129,378	100%	142,652	100%

Source: Northern Middlesex Area Commission, Nov. 1976

Table 3.3 Age Distribution of Population by Town

Age	Billerica No.	%	Chelmsford No.	%	Tewksbury No.	%	Westford No.	%
0-4	4,207	13.3	3,529	11.2	2,433	10.7	1,189	11.5
5-14	8,296	26.1	8,111	25.8	5,932	26.0	2,659	25.7
15-19	2,346	7.4	2,407	7.7	2,154	9.5	787	7.6
20-21	644	2.0	573	1.8	446	2.0	190	1.8
22-34	6,813	22.0	5,587	17.8	3,590	15.8	1,931	18.6
35-59	7,195	22.4	8,605	27.4	6,089	26.8	2,683	25.9
60+	2,147	6.8	2,620	8.3	2,111	9.2	929	8.9
Total	31,648	100%	31,432	100%	22,755	100%	10,386	100%

Source: 1970 United States Census

live in Tewksbury. The largest percentage of the population lies between the ages of 5-14 and 35-59.

3.4 Sex Distribution

The Southern Tier has an almost equal ratio of males to females according to the 1970 United States Census. The range of distribution for males is 49.2% in Chelmsford to 50.8% in Tewksbury, and for females is 49.2% in Tewksbury to 50.8% in Chelmsford. Taken as a whole, the sex distribution is 50% male and 50% female. The Lowell SMSA offers a slightly different ratio showing Women at 51.2% and men at 48.8%.

3.5 Race Distribution

Billerica has the largest number of Black residents with 153 (.5%). Tewksbury follows with 69 (.5%), Chelmsford with 67 (.25%) and Westford with 12 (.1%). A total of 301 Blacks live in this area, representing 0 .3% of the total population. This is less than the figure presented from the Lowell SMSA which has a Black population of 1114 persons or .5%. These figures vary significantly from those of Massachusetts, New England, and the United States, which have a Black population of 31.1%, 33%, and 11.1% respectively.

3.6 Spanish Language Population

The Spanish Language Population comprises a slightly higher portion of the area's population than do Blacks. The 1970 U. S. Census shows that in the Southern Tier, 308 persons (.4%) are Spanish language persons, with the highest percentage living in Tewksbury (189). The Lowell SMSA has a Spanish speaking

population of 1533 or .7%. In comparison, Massachusetts, New England, and the United States differ significantly with 1.1% 1.3%, and 4.6 respectively.

3.7 Educational Attainment

Table 3.4 presents educational attainment for each of the four towns. According to the 1970 U. S. Census, three of the four towns were above the Lowell SMSA attainment level; Tewksbury was the only exception. Adult residents of Tewksbury had a lower average of median school years completed (11.5) compared to the total four town average of 12.2 and the SMSA average of 12.1. In Tewksbury, the percentage of persons with high school diplomas was lower at 54.5% than the four town average of 63.4%, but equaled the SMSA's average.

Chelmsford, on the other hand, has a higher educational attainment level with the median school years completed being 12.6. This is above both the total four town average of 12.2 and the SMSA average of 12.1. The percentage of persons in Chelmsford with high school dipolmas is substantially above any of the other towns with 74%. This figure is 10.6% above the average of the Southern Tier and 19.5% above the SMSA total. Compared to New England, Massachusetts, and the United States, the percentage with high school diplomas in the four town area is higher, while the median school years completed is about equal.

3.8 Family Structure

Table 3.5 presents an analysis of female headed households in the area. Billerica had the highest number of female headed households in 1970 with 444. Of these, 112 or 25.2% were below the poverty level. Women who headed households

Table 3.4 Educational Attainment of Area Residents Aged 25 Years and Older, By Town, 1970

Towns	Median School Years Completed	Percent of Persons With High School Diploma
Billerica	12.3	61.2
Chelmsford	12.6	74.0
Tewksbury	11.5	55.5
Westford	12.3	63.9
Lowell	12.1	54.5
Mass.	12.2	34.9

Source: United States Census, 1970

and have children below the age of 18 compromise 20.5% of this figure.

In comparing percentages, however, Tewksbury had both the largest percentage of poor women who were heading households (28.4%) and the largest percentage of those that also have children below the age of 18 (26.2%). For both categories, Billerica and Tewksbury are above the total for the SMSA.

Table 3.6 indicates the number of widowed, separated, and divorced individuals in the four towns. The distribution of men and women who are widowed, separated, and divorced in the area is comparatively less than the percentage offered by the SMSA. Age statistics (Table 3.3) show that there is a small elderly population as compared to the other age groupings of the Southern Tier. Maritai status is most effected by those who are widowed. This number totals 3394 for the four town area. The largest number of widows reside in Chelmsford with 1170 persons (5.7% and the greatest percentage live in Tewksbury with 6.0% (901 persons).

3.9 Income and Occupational Status

Tables 3.7 and 3.8 deal with income distributions. Table 3.9 presents data on occupational status. The median income for each of the four towns is shown to be higher than the SMSA's which is $10,935. In comparison to the SMSA, the four towns have less people earning under $3,000. This also holds true for the United States and Massachusetts which have 10.3% and 6.4% earning less than $3,000 respectively. The towns have a substantially smaller percentage of people earning under $6,000. As incomes increase, the four towns have a substantially higher percentage of their people in each category.

Table 3.5 Female-Headed Households in Area, by Town, 1970

Town	Female-Headed Households	Female-Headed Households Below Poverty Level		Female-Headed Households Below Poverty Level With Children Under 18	
		No.	%	No.	%
Billerica	444	112	25.2	91	20.5
Chelmsford	469	55	11.7	55	11.7
Tewksbury	275	78	28.4	72	26.2
Westford	172	28	16.2	24	14.0
Total for 4 towns	1,360	273	20.0	242	17.8
Total for SMSA	5,495	1,271	23.1	1,101	20.0

Source: 1970 United States Census

Table 3.6 Compared Number of Widowed, Separated, and Divorced in Four Towns, to Lowell SMSA

Category	Billerica No.	%	Chelmsford No.	%	Tewksbury No.	%	Westford No.	%	Lowell SMSA No.	%	MASS %	US %
Widowed												
Male	202	.6	201	.6	246	1.0	77	.7	2,285	2.4	.5	3.0
Female	725	2.3	969	3.0	655	2.8	319	3.0	9,231	9.6	.8	12.3
Total	927	2.9	1,170	3.6	901	3.8	396	3.7	11,516	12.0	1.3	15.3
Separated												
Male	98	.3	50	.2	164	.7	22	.2	989	1.0	1.1	1.5
Female	133	.4	97	.3	92	.4	28	.2	1,509	1.6	5.2	2.2
Total	231	.7	147	.5	256	1.1	50	.4	2,498	2.6	6.3	3.7
Divorced												
Male	134	.4	109	.3	184	.8	32	.3	1,318	1.3	.7	2.7
Female	201	.6	208	.7	115	.5	76	.7	1,987	2.1	1.3	3.9
Total	335	1.0	317	1.0	299	1.3	108	1.0	3,305	3.3	2.0	6.6

Figures are for 14 years of age and older

The median incomes for unrelated individuals and families in all towns is higher than in the entire SMSA for the same population. Chelmsford is 33% above the SMSA figure; Westford is 22% higher; Billerica is 14% higher; and Tewksbury is above 10.6%.

On the average 88% of the four towns employed population are in moderate and high status occupations as compared to 80.6% for the entire population of the SMSA.

3.10 Housing

Table 3.10 shows characteristics of housing units. Prior to 1940, the area was industrial, and experiencing a moderate amount of housing unit expansion. During the 1940's and 1950's, when industry began to leave the area, the number of new housing units being built decreased. Within this time frame, a low of 232 housing units were built in Westford and a high of 634 in Billerica. Between 1950 and 1960, with the proposed highway linkage of Route 128 to the Northern Middlesex Region underway, new housing began to increase rapidly within the area. Tewksbury had a 40% increase in new units which was well above the SMSA average of 16% for that period. There was a 31-49% increase in construction between 1960 and 1970.

Overcrowding does not appear to be a major problem in the Southern Tier. Renter occupied homes suffer more from overcrowding than owner occupied homes. One percent of the region's population lives in owner occupied dwelling with 1.51 or more persons per room. Tewksbury and Billerica surpass this figure with 1.6 and 1.7. For the renter occupied category, 1.5% of the residences have 1.51 persons per room. Again this is surpassed in Billerica with 2.1% and Tewksbury with 3.9%. Chelmsford and Westford both fall below the regional average with .9%.

Table 3.7 Distribution of Family Incomes of Area, by Town, In Comparison to the Lowell SMSA, the State, and the U.S.

Income Range	Billerica No.	%	Chelmsford No.	%	Tewksbury No.	%	Westford No.	%	Lowell %	Mass %	U.S. %
Under $3,000	294	4.0	177	2.4	40	.9	138	5.5	6.0	6.4	10.3
3,000-5,999	587	8.0	316	4.2	312	6.8	169	7.8	11.0	11.8	15.7
6,000-9,999	1,767	24.0	1,163	15.5	1,013	22.0	565	22.4	26.0	25.7	26.7
10,000-14,999	3,110	41.2	2,726	30.3	1,996	43.4	955	37.0	34.0	30.9	27.6
15,000+	1,615	22.8	3,132	41.6	1,236	26.9	687	27.3	23.0	25.2	20.0
Total	7,373	100%	7,514	100%	4,597	100%	2,514	100%	100%	100%	100%
Median Income											
All Families	11,274		12,645		11,599		12,093		10,935	10,835	9,590

Table 3.8 Median Incomes for Unrelated Individuals and Families in Area, by Town, In Comparison to Lowell SMSA.

Town	Median Income	% - Lowell SMSA
Billerica	$10,872	14.0
Chelmsford	$12,645	33.0
Tewksbury	$10,515	10.6
Westford	$11,599	22.0
Lowell SMSA	$ 9,506	-

Source: 1970 United States Census

Table 3.9 Occupational Status For Employed Persons, Age 16 and Older, by Town

Occupational Status	Billerica %+	Chelmsford %+	Tewksbury %+	Westford %+	4 Town Area %+	Lowell SMSA %+	Mass. %+	New England %+	U.S. %+
High*	26.2	44.0	25.7	35.0	27.4	33.0	26.0	25.6	25.0
Moderate **	54.7	42.8	55.9	47.8	53.2	50.0	40.0	39.4	38.9
Low***	19.1	13.2	18.4	17.2	19.4	17.0	34.0	35.0	36.1
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%

+ Percent of total numbered 16 and older employed in 1970

* Professional, Managers, and Administrators

** Sales and Clerical Workers, Craftsmen, and Foremen

*** Operatives, Laborers, Farm Workers, Service Workers, and Private Household Workers

Source: 1970 United States Census

Table 3.10 Characteristics of Housing Units in the Area, by Town

Characteristics	Billerica No.	%	Chelmsford No.	%	Tewksbury No.	%	Westford No.	%	Lowell SMSA No.	%	Mass %+	New Eng. %+	U.S. %+
Housing Built Prior to 1940	2365	29	2231	26	1068	20	1120	39	32,432	52	61	57	41
Housing Built between 1940-1950	634	8	471	6	452	9	232	8	3,955	6	8	9	13
Housing Built between 1950-1960	1561	19	1652	19	2082	40	583	21	10,213	16	15	16	21
Housing Built between 1960-1970	3477	44	4197	49	1625	31	901	32	15,863	26	16	18	25
Total	8037	100%	8551	100%	5227	100%	2836	100%	62,463	100%	100%	100%	100%
Median Value of occupied housing Unit	$19,900		$23,733		$26,225		$22,466		$19,300		$20,800	$20,700	$17,000

+rounded to nearest percent

Source: 1970 United States Census

Crowding is generally associated with large families. The regional average for a large family in a crowded unit is 7.3 people in an owner occupied home and 6.4 people in a renter occupied unit. Tewksbury has the highest percentage of its population in overcrowded units although Billerica has the greatest number of crowded units and the largest number of people in those units. Chelmsford and Westford have the lowest number of their population in crowded units. This holds true for both owner and renter occupied sites.

3.11 Welfare

Table 3.11 shows the incidence of welfare recipients by town for July 1978. Table 3.12 shows welfare assistance caseloads by town. As of July 1978, 4756 residents were recipients of public assistance. This represents 4.6% of the population receiving assistance (using 1975 population statistics).

There were 1162 public assistance cases of AFDC and GR and 1258 Medicaid only cases. The incidence of cases in Billerica and Tewksbury is above the overall incidence in the Southern Tier. Chelmsford and Westford are below the area incidence rate.

In comparing towns in terms of the number of AFDC, GR, and Medicaid Only cases, Billerica has the largest number, then Tewksbury, followed by Chelmsford and then Westford having the least. In the total four town area the number of cases is substantially lower than in the Lowell SMSA. (Massachusetts has an 11.1% incidence rate, far above that of the four towns.)

Table 3.11 Number of Welfare recipients by Town

Town	Population **	Recipients*	Incidence %
Billerica	35,831	2,263	6.3%
Chelmsford	31,749	813	2.6%
Tewksbury	24,048	1,342	5.6%
Westford	12,741	338	2.7%
Total	104,368	4,756	4.6%
Mass.	5,789,478	642,665	11.1%

*AFDC & GR Figures for FY 1977

**Source: 1975 State Census (Mass.)

Table 3.12 Numbers of Welfare Assistance Caseloads in Area, by Town, FY 1977

Assistance	Billerica	Chelmsford	Tewksbury	Westford	Total	Mass.
AFDC	513	181	235	83	1012	4509
GR	45	36	65	4	150	696
Total	558	217	300	87	1162	5205
			M E D I C A L O N L Y			
AGED	229	182	214	64	689	1783
AFDC	99	28	66	16	209	375
DISABLED	51	18	47	7	123	359
CHILDREN UNDER 21	109	38	79	11	237	715
Total	488	266	406	98	1258	3232

Source: Mass. Dept. of Public Welfare - Statistical Supplement to Annual Report FY '77

3.12 Conclusion

In summary, the socio-demographic data gathered by the Planning Lab presents an overview of the population characteristics, growth trends and economic development of the Southern Tier. From this data, certain assumptions can be made concerning service needs of the community. The next chapter further examines the extent and scope of services being offered in the Southern Tier.

* * * * * * *

CHAPTER IV: RESOURCE INVENTORY

4.1 Introduction

This section describes the social service system that presently serves the needs of the Southern Tier. To accomplish this, a comprehensive and systematic examination of the human service system is necessary. The most applicable framework for the Southern Tier is the United Way American Service Identification System (UWASIS) which incorporates the following characteristics:

(1) Comprehensiveness: It attempts to include all those elements essential to the healthly growth and development of the individual and the community;
(2) Universality: It applies to all communities; and
(3) Flexibility: It allows for change within service systems without threatening its basic structure.

The stated purpose of UWASIS II (a revision of UWASIS I) is "not only to provide a tool for 'sorting out' but to provide a chart of human efforts to deal with ourselves." Specifically, UWASIS II "describes programs within the framework of fundamental goals in the field of human services." It outlines the basic social goals, the service systems which promote such goals, the specific services in such systems, and the programs which perform such services. UWASIS II delineates the eight fundamental goals listed below; these are described more thoroughly in the appendix:

(1) Optimal Income Security and Economic Opportunity;
(2) Optimal Health;
(3) Optimal Provision of Basic Material Needs
(4) Optimal Opportunity for the Acquisition of Knowledge and Skills
(5) Optimal Environmental Quality;
(6) Optimal Individual and Collective Safety;
(7) Optimal Social Functioning; and
(8) Optimal Access of Support and Effectiveness.

Through a process of adaptation and modification, a UWASIS framework for the Southern Tier social service system is developed. In this way, a clear picture

is constructed of public and private services that are presently available and how they fit into the overall social service system. The eight goals of UWASIS are considered into six basic social goals, as stated below:

Goal I: Optimal Income Security and Economic Opportunity
This goal is optimal income security and economic opportunity for all individuals. The service systems are geared to: provide gainful employment for all able and willing persons; secure income maintenance for the eligible and needy; and promote economic conditions conducive to healthy and study trade growth, business opportunity, minimal inflation, and currency stabilization.

Goal II Optimal Health
This goal is the attainment of an optimal level of well-being for all individuals. The service systems are geared to the promotion and maintenance of health, treatment, and where feasible, cure of disease and rehabilitation of the handicapped.

Goal III Optimal Provision of Basic Material Needs, Optimal Individual and Collective Safety, and Optimal Environmental Quality
This goal includes the provision of basic material needs for the functioning of an individual in society. They include food, clothing, shelter, household goods, and transportation services. The service systems are geared to the provision of food, apparel, housing and safe transportation. This goal includes the optimal level of individual and collective safety. The service systems of this goal include: the protection of persons and property; the administration of justice, disaster protection and relief; and consumer protection and safety. Also included is the societal goal of preserving and protecting the environment.

Goal IV Optimal Opportunity for the Acquisition of Knowledge and Skills
This goal involves providing optimal opportunity for every one in society to acquire optimal social functioning in the broadest sense of the terms--optimal social, economic political, and intellectual participation in society. The service systems are geared to the formal, informal, and supplementary education of the individual.

Goal V: Optimal Social Functioning
This goal exists to enable individuals to function in society at the optimal level of their capacities and potentila. The service systems are geared to preserving and strengthening individual and family life and to creating and promoting conditions conducive to personal growth, thus enabling individuals to lead a personally satisfying, enriching, and socially useful life in harmony with family, friends, and colleagues.

Goal VI This goal is the achievement of an optimal degree of assurance for the maintenance of effective and efficient delivery of human service programs as needed, and for the development of new programs in response to current and future needs, through organized social and political action. The service systems are geared to the social and political mobilization of people; the development of human and material resources; the allowance for organizational capacity building; and the enhancement of service effectiveness.

In order to classify the services provided by the various agencies, the 1976 Human Resources Directory of Greater Lowell, prepared and developed by the Consultation and Education Department of the Solomon Mental Health Center, is examined. After the directory was updated, over 125 agencies were classified within the UWASIS framework. The resource directory now provides the following information: agency name, agency goal, agency purpose, services offered, and eligibility. From this information, it is possible to compile a classification of agencies. Agencies having similar overall objectives are grouped together under a service category. In most cases, specific programs are not delineated; rather, the agencies having programs which provide services within a given service system are listed. However, some programs are specifically noted such as, Food Stamps, WIN, Premature Parenthood, etc.

In this way then, the UWASIS provides a format for examining basic

relationships between various goal areas and agency operational systems. The UWASIS can note gaps in service systems and possible linkages among agencies providing a specific service. It is important to note here that the UWASIS does have limitations, and cannot be used as a planning instrument in and of itself. However, when used in conjunction with an indepth needs assessment and socio-demographic data, the UWASIS is a useful tool in the planning process.

As regards its limitations, it should be mentioned that the UWASIS does not address the issues of quality, capacity, or accessibility. Also, it is not capable of providing analysis of the differences among similar programs provided by different agencies.

Building upon the UWASIS, an age cohort is devised which classifies agencies and programs in relation to specific age groups which they are designed to serve. This is valuable in assessing services available for age specific target populations ("at-rish groups") such as youth and the elderly.

4.2 Findings

As previously stated, linkages and gaps can be discovered through the UWASIS. (See Addenda). Under each of the eight goals, agencies providing similar services offer possible areas for integration. Other categories of agencies for which no agencies exist indicate gaps which can be addressed in future planning. In the following pages, these gaps and linkages are discussed as they relate to each goal.

Goal I: Optimal Income Security and Economic Opportunity

A cluster of seven agencies deliver services under the category of Special Employment Services for Exceptional Individuals and Groups.

Two of these agencies, the Massachusetts Rehabilitation Commission and the Massachusetts Commission for the Blind, are among the eight participating agencies on the ASPT. Most of the other categories involve financial support which are often provided by state and federal agencies, such as the Department of Economic Security and the Social Security Administration.

As one looks closely at this goal, through the use of the Age Cohort, some gaps in service emerge. Between the ages of fourteen and twenty-one, two programs providing employment training services are available. Both have categorical requirements constraining the use of their services. CETA serves only low income persons, while the Lowell Diversion Project services only juveniles in trouble. Between the ages of twenty-two and fifty-nine, however, CETA is the only program available. While many people in this age bracket need employment training, they do not qualify for CETA because of categorical financial constraints. Unless an individual falls into a specific income category (low), then an agency does not exist to provide job training.

Individuals aged sixty and over have only two agencies that can train them for work. Community Teamwork, Inc., under the Foster Grandparent Program is one agency providing the elderly with job training; the other is Elder Services. With longer life spans and a lower retirement age, a definite need for job training of the elderly exists.

Goal II: Optimal Health

Numerous agencies offer services under this category since it includes both physical and mental health. Although medical care is an obvious necessity and has many providers, it does not have representation on the ASPT.

ASPT members may contract with hospitals but the resource directory of UWASIS does not offer this information.

Given the fact that large numbers of agencies provide health services, clusters can be identified. Five agencies provide homemaker-home health assistance. Five hospitals have inpatient services, and six have outpatient medical care facilities. Three of these hospitals contain emergency medical rooms, but none of these is located in the Southern Tier.

Two other health services involve clusters of agencies: Fertility Regulation and Rehabilitation Services. The former relates to family planning and has five agencies. The latter referring to physical rehabilitation, has six (agencies).

An investigation of mental health programs reveals a number of agencies offering similar services. Six agencies are listed under alcoholism prevention and treatment; none of these is located in the Southern Tier. Four come under the heading of outpatient psychiatric services. The largest grouping of agencies involved with this goal can be categorized as Crisis Intervention and Protective Services. Seventeen agencies claim they perform this function. Of these, four (Solomon Mental Health Center, Department of Public Welfare, The Massachusetts Commission for the Blind, and Elder Services of Merrimack Valley) participate on the ASPT. It is interesting to note that although a large cluster exists, none of them provides twenty-four hour emergency service.

In the Developmentally Disabled Services Category, few residential services are available. Only two providers are listed here. The Walter E. Fernald State School is a state institution located in Waltham, Massachusetts, well outside the

boundaries of the Southern Tier. The Greater Lowell Association for Retarded Citizens cannot possibly service all the individuals needing their help. A wide gap presents itself here and demands re-examination in future planning.

Goal III: Basic Needs and Collective Safety

Transportation services are the most notable listing. Few clusters are evident anywhere. Only one agency provides transportation to the blind; two serve the elderly; three serve the handicapped; and four serve the medically needy. As regards the latter, only specific clients can use the services. This is because the American Cancer Society, the Muscular Dystrophy Association and the Merrimack Right to Life provide services only within certain categorical restrictions.

None of the agencies listed in the resource directory have emergency transportation services. If this type of service is not provided, then a large gap exists in available services. As well, the transportation providers mentioned above cannot or are unable to adequately serve the entire Greater Lowell area. Oftentimes, agencies that do provide transportation use volunteers and that may not prove to be the most efficient service system. Also, the public transportation system in the area is not especially good. As such, many physically disabled clients are unable to use public transportation.

The other categories deserve attention. Five agencies provide legal aid and public defender services. Four agencies offer crime and delinquency prevention services. Of these four, prevention is not the primary function of three--the YMCA, YWCA, or the Boys' Club. The Lowell Diversion Project is the only agency that focuses primarily on crime prevention.

Goal IV: Optimal Opportunity for the Acquisition of Knowledge and Skills

Supplementary Education Services is a category supported by many agencies. This includes adult and continuing education. Six agencies state that they perform these functions. Many public schools and higher educational institutions also provide these services even though they come outstide of what is normally considered their role.

The largest cluster falls under Special Education Services for the Gifted and Disadvantaged. The Merrimack Education Center in Chelmsford is the only agency of this type located in the Southern Tier. All the other providers are situated in Lowell. Therefore, if a person does not meet the eligibility requirements of the six agencies or if the agencies are at full capacity, the individual must go to the Greater Boston area. With inadequate public transportation in the Southern Tier, an unwarranted burden is placed on the individual or family seeking these services.

Preschool services, although listing four providers, are not adequate, even though early intervention programs are currently recognized as a major mechanism for detecting and arresting future problems. Since a child's formative years lie within the ages of between birth and six, (depending upon the child's developmental level), early intervention becomes a key factor for acquiring proper individual growth.

The early Childhood Development Team alone provides this service and cannot possibly serve all the needs of Greater Lowell.

Goal V: Optimal Social Functioning

Counseling is offered by almost half the agencies listed in the resource directory. The differences lie with the type of counseling provided.

Twelve agencies offer general counseling for those with generalized problems; nine agencies counsel only individuals with specific mental or physical disabilities; and six agencies provide alcohol and controlled substance abuse counseling services.

A number of agencies counsel individuals having family problems. While six serve those with family and marital strife, four serve unwed pregnant women and unwed mothers. In addition, six agencies provide specific counseling for youth. A noticeable gap in family counseling appears in the area of single parent family development. Only one agency reports that it serves this population

Moreover, further investigation reveals that family services are sometimes provided through family substitutes or foster care. Eight agencies offer this service; most of them contract out for foster care and thus, are not directly providing this type of service. The number of actual foster care homes available cannot be determined by reading the directory, and therefore, deficiencies are undefined.

Two large clusters appear under the Social Group Adjustment and Development Service listing. Eleven agencies deliver recreational services; most of these involve the seven through twenty-one age group. Few recreational facilities are geared toward individuals between the ages of twenty-two and fifty-nine or those sixty and over.

The second cluster involves Social Group Adjustment Services. This category deals with agencies that use group support techniques as a method of conquering the proglems of "at-risk" populations. The agencies in this grouping include Alcoholics Anonymous, Al-anon, and Gamon. Nine of them serve the fourteen to twenty-one age group. Eight also serve the twenty-two to fifty-nine age bracket. Of these,

three serve those sixty and above.

Goal VI: Adequately Organized Social Instrumentalities

To some extent, information and referral services are performed by twenty-six agencies. Although many agencies are listed, few, if any, do it as a separately organized function. Many provide this service only as it pertains to their specific role--i.e., the American Cancer Society and the March of Dimes.

The next largest group, twenty-one agencies, comprise Community Education and Public Information Services. Here, too, many provide these services solely for their specific clientele--i.e., The National Foundation for Ileitis and Colitis).

Three separate, smaller clusters appear under Advocacy, Community Organizing, and Research. Eight agencies provide advocacy for specific client groups including children and the mentally ill. Five agencies involve community organizing to pull groups together for support of specific interests. And finally, another cluster of nine agencies centers around research. These, too, are essentially groups or associations limited to dealing with a specific disease or problem.

4.3 Conclusion

Groups in service and clusters of agencies have been reviewed as they relate to the previously detailed six goals of UWASIS. Large clusters become visible under Information and Refferal, Community Education and Public Information, Counseling, Recreation and Crisis Intervention. Large gaps are apparent in Transportation, Early Intervention, Crime Prevention, Residential Services, and Employment Services for the Elderly. The major problem in the Southern Tier is the fact that most of the relevant agencies are located in either Lowell or Boston, both cities outside the Southern Tier.

A study of Table 4.1 shows most agencies located under Goals V and VI. Most of Goal VI's agencies are listed under Community Education and Public Information and Information and Referral. Most of Goal V's agencies perform counseling services. Although the largest percentage of agencies concerned with Goals V and VI serve all ages, the largest single group served is between the ages of fourteen and twenty-one. This holds true for every goal. In fact, in Goal I, the fourteen to twenty-one age bracket contains more service providers than do all the other age brackets. The least served groups are the smallest numerical groups in the Southern Tier.

Gaps in services can be addressed through a competent planning process. Clusters can be seen as possible sources for integration or joint programming. They can also be viewed as sources of competition. Where similar services are available to clients, agencies can be asked to compete for those clients, thereby making them more responsive to individual needs. Gaps and services are again discussed in later chapters.

* * * * * * * *

Table 4.1 The total number of Agencies and the Percent of Agencies which served specific age groups.

Goals	# of Agencies listed	% of Agencies serving different age groups					
		Birth-6	7-13	14-21	22-59	60+	All
I	13	0	7	84	69	15	23
II	36	13	22	41	33	16	72
III	33	3	12	27	15	9	51
IV	19	36	42	47	21	21	47
V	59	13	23	27	22	16	54
VI	52	5	5	19	13	11	73

SOURCE: The 1976 Human Resource Directory of Greater Lowell

CHAPTER V: SURVEY OF ASPT AGENCIES

5.1 Introduction

This chapter considers the results of a survey conducted by the Boston College Planning Lab. The purpose of the survey was to ascertain the extent to which ASPT member agencies perceived their involvement in the proposed multi-service center, given the fact that these agencies would be involved, to some degree, with the direct service delivery of the center. Also included in this chapter is a discussion of the objectives of the survey, the methodology used, and an analysis of the findings.

5.2 Objectives of the Survey of Agencies

The objectives of the survey are:

(1) Determination of priorities of ASPT agencies for services within the center based upon their perceptions of community needs;
(2) Examination of existing and potential linkages among participating ASPT agencies;
(3) Commitment of agencies to the center in regard to existing and potential funding and staff allocations;
(4) Indication of present service activities of agencies within the defined catchment area of the center (Southern Tier), and
(5) Identification of issues regarding implementation of the center as perceived by ASPT agencies.

5.3 Methodoloy

Based on the above objectives, a survey composed of thirteen questions was prepared and developed by the Boston College Planning Lab. Following completion of the first draft, a copy of the questionnaire was submitted to the Lab's faculty advisor at Boston College for initial review and comment. Based on his recommendations, a second draft was prepared and submitted to the ASPT. Revisions were again made, and then, the final draft of the questionnaire was administered to ASPT member agencies. A cover letter was mailed with the questionnaire, describing the purpose and nature of

the survey. In all, eight questionnaires were administered. The next week, a follow-up procedure was conducted; by telephone, interview appointments with Boston College Lab members were made. Scheduled personal interviews lasted approximately 45 minutes. The purpose of the interview with an agency representative and Lab member was to complete the questionnaire and to clarify responses.

5.4 Findings of Survey

After review and evaluation of questionnaires, the following survey findings were noted, (See Addendum):

(1) Service Priorities

A summary of the agency responses regarding their top four service priorities (to be administered from the multiservice center) indicates that there is a vast range of opinions regarding services that should be provided from the center. However, responses also indicate that certain commonalities are present. It was noted by several agencies that the following services should definitely be provided; Counseling (individual and family); Information and Referral; Advocacy; Employment Related Services; Psychiatric Evaluation and Diagnosis; and Intervention Services.

In terms of how agency priorities were derived, the survey indicates that six of the eight agencies determined priorities through an assessment of consumer needs. The mechanisms for consumer input to the various agencies ranged from direct agency-client involvement (i.e., needs assessments, public hearings, etc.) to some form of advisory consumer board or council which provides input to the agency's decision making body. When asked if any changes in priorities would occur within the next five years, five agencies replied "none at present". The remaining three stated that greater

emphasis would be given to the following areas: Case Management; Advocacy; Transportation; and Out-Patient and At-Home Services.

(2) Service Activities of ASPT Agencies in the Area

In reference to current activities of ASPT agencies in the area, the survey shows that although only two agencies have direct service offices in the four-town region, all agencies serve clients in that area. Of the agencies surveyed, all have acknowledged that in the four town area, Billerica is the largest consumer of services, followed by Chelmsford and Tewksbury, respectively. Although some agencies were not able to supply population characteristics of clients, (due to variation in data recording) those that did, indicated that families (ages birth to 21 and 35 to 59) and the elderly (ages 60 and over) comprise the two largest groups around which service activities are focused.

(3) Staff Allocation

In response to the question regarding staff allocation for the multi-service center, four agencies were able to make a firm commitment to providing staff at the time of the center's opening. The amount of staff time offered varied considerably. One agency indicated a commitment of 2 or 3 full time people; two other agencies committed one staff person for one half day per week.

It is assumed that these responses reflect the agencies' present ability to allocate staff. In the future, as the center's activity increases, it is hoped that all agencies will be able to assign more staff to the center.

(4) Funding

An analysis of the current funding sources of the agencies surveyed indicates that all eight agencies receive most of their monies from some form of government appropriation. These appropriations consist of either Federal grants/Entitlements or State funds. All eight agencies receive some federal funding, while one agency derives funding totally from federal appropriations. Five agencies receive state funding. Only one agency derives the majority (90%) of its funding from local taxes. In terms of commonalities, half the agencies listed Title XX as a major funding source.

As regards future funding, six of the eight agencies indicate that they expect new funding in the future, predominately in terms of federal monies. Of these six, four anticipated new monies coming from an increase in existing grants, whereas, two forsee money flowing from new grants.

(5) Purchase of Services

In terms of services purchased by ASPT agencies, six of the eight agencies indicate that they purchase services from outside agencies. Generally, these services are from agencies within the Lowell or Southern Tier area. The services vary considerably, depending upon the speciality of the particular agency. However, the majority of services purchased revolve around: transportation: medical aid; evaluation; homemaker services; and staff training.

Regarding services purchased from the eight agencies, all indicated that no outside agency purchases services from them.

(6) Present Interaction

Presently, there appears to be limited interaction among the eight ASPT agencies. In terms of frequency and types of interaction, the majority of inter-agency contact regards information and referral, and case consultation. This is followed in frequency by planning and coordination functions. All eight agencies report sharing in some sort of planning and coordinating activity with all other agencies on the ASPT; it is assumed that this is in reference to monthly ASPT meetings. As far as funding and technical assistance is considered, the responses indicate that there is generally limited interaction. None of the agencies interacts with another regarding staff sharing and/or professional growth and training.

(7) Issues in Implementation

The question concerning issues and constraints anticipated in implementing the center received a wide range of responses. An analysis of the frequency of common concerns, however, reveals that major issues are commonly perceived by the ASPT agencies. They include: duplication of services; evaluation; staffing (allocation, deployment, etc.); and the authority of ASPT to make decisions in the center.

5.5 Conclusion

In summary, the survey of ASPT agencies indicates an overall commitment on the part of these agencies to the proposed multi-service center. Although the resources (i.e., personnel and funding) contributed by each agency is limited at this time, it is indicated that an increased commitment is forthcoming as the center develops and expands its activities. In terms of potential center services, the survey notes that Information and Ferreral Counseling should be given careful consideration. Further,

the survey shows a potential for collaboration on the part of ASPT agencies in terms of funding and services purchased. In reference to possible problem areas in center implementation, a majority of the sampled agencies note that issues of authority, duplication of services, commitment, and evaluation should be seriously considered.

The next chapter provides a more detailed evaluation and synthesis of the survey in conjunction with the socio-demographic data and resource inventory discussed in the preceding two chapters.

* * * * * * * * *

CHAPTER VI: SYNTHESIS, ANALYSIS, AND PLANNING GOALS

6.1 Introduction

This chapter presents a synthesis of the knowledge gathered from the review of the literature, the socio-demographic profile, the resource inventory, and the survey of agencies. The data collected from all four sources yields information offering additional insight and direction useful in attempting to arrive at specific planning goals. The findings can be used for several purposes. First, they provide a clear picture of the specific problem to be addressed by the plan. Second, the information offers a means for determining a multi-service center delivery system needs and priorities. Third, the problematic areas in the design and implementation of the multi-service center in the Southern Tier are delineated and finally, the findings and information can be translated into appropriate goals and recommendations.

As the first step in this chapter, the information from the socio-demographic profile, resource inventory, and survey of agencies is combined to formulate service priorities. These priorities are perceived as important delivery system needs and service priorities of the Southern Tier's multi-service center.

Next, the knowledge gleaned from the review of the literature and agency survey is synthesized and presented as issues. These issues are statements of problematic areas of which a planner must be cognizant in designing a service integration project.

Then, the combination of all the information and data specifically defines the problem(s) in the Southern Tier. Both priorities and issues become guides in the consideration and final selection of specific goals and objectives of the planning task.

The last section of the chapter presents definite, current goals based upon an analysis and synthesis of all sources of information.

6.2 Priorities

Service delivery system needs and priorities, as determined by the socio-demographic profile, resource inventory, and survey of agencies, are discussed in the following paragraphs.

Counseling is the most frequently mentioned priority in the agency survey. From the socio-demographic study, the Planning Team found that the population of the Southern Tier includes large groups of youths (5-14) and middle-aged persons (34-59). From this data, one can assume that, for the most part, families reside in the Southern Tier.

Certain problems are associated with families--child abuse, wife abuse, substance abuse, marital strife, and adolescent adjustment problems, to name a few. Too, the problems of the participating agencies' target populations, such as the handicapped, blind, and emotionally disturbed, have an impact on the family.

Information and Referral is viewed as a priority by several agencies. The agency survey shows that interaction between agencies occurs most frequently because of this function. The resource inventory shows that specific individual agencies perform this function with no common information and referral system existing. Therefore, a common information and referral system is recommended by the Planning Lab as a mechanism for service integration.

Outreach and Community Education are also priorities listed by the agencies. Although the largest population at present is residing in Billerica (the smallest is in Westford), the Planning Lab, noting growth pattern, predicts that the populations of Westford and Tewksbury are going to grow more rapidly than either Billerica or Chelmsford

in the near future. Outreach to these communities is necessary. The resource inventory shows that agencies perform their own outreach, but that no common outreach effort exists. The Lab, therefore, recommends this as a component of the multi-service center.

Crisis/Family Intervention, too, has been delinated as a priority by the agencies. An analysis of the resource inventory points to a lack of adequate around-the-clock crisis intervention service. The Lab recommends that this type of service be a center priority. The Lab realizes that residential services could also be a part of the intervention process, but they are lacking in the area.

Transportation is also expressed as a priority. The resource inventory suggests a gap in definite transportation services. An inadequate public system in the Southern Tier makes access to services difficult. Target populations such as the blind, the handicapped, and the elderly have limited mobility and they deserve consideration regarding special transportation services.

Advocacy is considered a priority by two agencies. Target populations need advocates to obtain proper services and entitlements.

6.3 Issues

The review of the literature and the survey of agencies point out certain issues. They are considered in the following discussion.

First, Limited Resources impact upon service integration projects should be explained. The agency survey reported that one limited resource is personnel. Often times, insufficient resources impede the integration process, since agencies cannot commit themselves to new projects without effecting existing operations.

Second, Funding involves two dimensions. One is the continual funding of service integration projects after the initial grant money has expired. The other is the optimal use of funds in delivering social services. In order to maintain the integration efforts, new funding sources must be acquired. With respect to funding direct services, problems arise from the categorical nature of service delivery and funding. The "top down" approach is controlled by rigid categorical programs that are difficult to alter.

Next, Leadership is a variable that encompasses effective and efficient management of a service integration project. Often, the success or failure of a service integration project is determined by the quality of leadership. Integration requires change, and this demands the efforts of an effective change agent.

Consensus Building is another important factor if service integration is to become a reality. A commitment to mutual goals and objectives must be shared by all participants. Projects work best when state and local governments work together and true consensus is not possible without the active participation of local citizens.

Costs are seldom reduced. Program effectiveness, however, is an immediate benefit of service integration projects. Through shared services, economies of scale are achieved.

Information System is also an important ingredient of an integration effort. Integration depends on easy access and availability of information. An MIS is difficult to establish in a complex system, but once established, it becomes the cornerstone of a well-integrated social service network.

Finally, "Turf Issues" arise when agencies coordinate and integrate services, particularly with colocation. A sacrifice of former identity is demanded. This means

a loss of autonomy, which is threatening to agency integrity. Former terrains must be surrendered. Turf issues tnat erupts in terms of joint programming and joint funding can hinder or arrest an ongoing process of integration. Colocation of agency personnel raises turf issues in that uniform personnel practices among agencies rarely exist. Agencies have various status positions and different pay scales; this can cause conflict.

Because all these problematic areas exist, service integration is a slow evolutionary process. Integration is a change imposed on an already-established environment and is, therefore, met with resistance. Service integration, must sometimes "unfreeze" institutions to succeed in altering the present service delivery system.

6.4 Restatement of the Problem

The problem, as originally perceived by the Area Strategy Planning Team, includes several dimensions. First, services in the Southern Tier are inaccessible to clients. Too, the service delivery system is not an integrated system offering a client easy access to a full range of services. Agency efforts are uncoordinated, and therefore, services delivered are unresponsive to client needs.

The Boston College Planning Lab's in-depth study of the problem provides support for the ASPT's initial observation. The data collection effort further delineates the dimensions of the problem in the problem in the Southern Tier.

To reiterate, services in the Southern Tier are not accessible. Although all eight agencies are involved in serving the population residing in this area only one agency (DPW, Assistance Payments) is actually located in the Southern Tier. Most agencies are located in Lowell . A serious gap in transportation services contributes to the problem of accessibility. While some special transportation services are available,

target populations (such as the blind and handicapped) have acute mobility problems. Agencies note that their service priorities include Independent Living, Outpatient Care and Day services. This kind of community based care demands that services be easily accessible to residents of the community.

It has been shown that services in the Southern Tier are not well integrated. There is no one single entry point to an entire system of services. A client must enter each system separately. With no common intake, information and referral, and client tracking system, services are fragmented. Thus, clients are not offered continuity of care.

The study of the existing social service system illustrates clusters of agencies providing similar or complementary services. Potential linkages could be developed in order to create a more integrated system. The survey reported, though, that the eight agencies experience little interaction regarding joint programming activities.

Agency efforts are not coordinated. Efforts of the ASPT are steps in that direction, but, for the most part, each agency continues to function separately. For example, information and referral functions are performed by each individual agency. This represents much duplication of effort and a lack of coordination.

Although gaps in services exist in the Southern Tier, there is little joint planning and coordination at the present time. Joint planning offers an appropriate means of finding soltuions to commonly defined problems. Activity, however, in terms of coordination and planning is minimal.

Funding sources of the eight agencies show some similarities with Title XX funds being a source of revenue for a number of agencies. All agencies, however,

are restricted by the categorical nature of the funding sources. The manner in which services are funded leaves its impact on poor service integration and coordination; it makes services unresponsive to consumer needs. Decisions about funding are not made locally;- - -want allocation and re-allocation of staff are not made at the local level. This top down approach makes it difficult for the system to put together a complete package of services for any one individual.

Services delivered by the eight agencies are restricted by present funding methods. The literature points out that categorical funding practices curtail service integration and limit the service delivery system's effectiveness. The categorical grant system is a major cause in the lack of coordination and integration.

To deal with these problems, the LASPT has decided on the multi-service center as a mechanism for integration.

6.5 Planning Goals

Considering the analysis of the problem, the Boston College Planning Lab is now faced with the task of designing a plan which addresses the problem and provides mechanisms for adequately dealing with them. It is necessary to select appropriate goals for the planning effort to arrive at the desired ends.

The ultimate goal of the planning task is: TO CREATE A WELL INTEGRATED AND COORDINATED SYSTEM THAT IS AVAILABLE, ACCESSIBLE, AND RESPONSIVE TO CLIENT NEEDS.

In order to realize this, certain objectives are recommended as a means through which the ultimate goal is reached. This ultimate goal is: TO DESIGN AND

PUT INTO OPERATION A MULTI-SERVICE CENTER FOR THE SOUTHERN TIER. The objectives to achieve this actually become additional goals of the planning effort. They include:

GOVERNANCE: To create a policy-making body that is adequately represented by consumers, providers, and local officials.

ORGANIZATIONAL STRUCTURE: To create an organizational structure that facilitates optimal internal functioning of center and staff.

CORE SERVICES: To design a variety of shared common core services, including intake, diagnosis, referral, monitoring, follow-up, advocacy and outreach.

EVALUATION: To create an evaluation component that measures the effects of the center.

PROGRAMMING AND PLANNING: To create a mechanism for joint planning and programming.

FUNDING: To create a financial base for maintenance of the system.

6.6 Conclusion

These eight planning goals and objectives are broad statements related to the end result of the planning effort. There are separate tasks and specific activities involved in order to reach each goal. In the following pages, goals are more closely explored and delineated, and the activities involved in fulfilling each of the objectives is explained.

* * * * * * * * *

CHAPTER VII: THE PLAN

7.1 Introduction

This chapter presents specific planning recommendations for the necessary elements of a multi-service center for the Southern Tier. These elements include governance, organizational structure, staffing patterns, core services, planning and programming, funding and evaluation. Each element is designed in terms of the brokerage concept described in the Review of the Literature.

The elements are presented in three phases. Each phase corresponds to approximately one year. They are only approximate time lines, since it is impossible to determine all variables impacting upon the implementation process (see addenda for measure analysis, examples of function analyses, and matrices for the outlined phases).

7.2 Governance

IT IS RECOMMENDED THAT A PLURALIST MODEL OF GOVERNANCE BE ADOPTED AS THE POLICY MAKING BOARD OF THE CENTER.

In order to assure full accountability to the entire community, the governing board should be fairly represented by providers, consumers, and local officials. The board should consist of twenty-four members having an equal number of providers (8), consumers (8), and local officials (8(. Terms of membership should be staggered to provide for continuity, one half of the consumers and local officials should have a two-year term while the other half serve a three year-term.

A pluralist model of governance necessitates a board that represents a wide range of interests and becomes a mechanism that can build consensus and support in all sectors of the community. A study of the various models of governance points

out that this model is the most successful governing body in achieving effective results.

The pluralist model is a long range goal and can be accomplished in three phases. At first, the board should begin as a provider board and move towards the integration of consumers and local officials.

PHASE I

Members of the Area Strategy Planning Team should assume the role of governance. The members include one representative from each of the eight agencies -- Massachusetts Commission for the Blind, Massachusetts Rehabilitation Commission Department of Public Welfare, Department of Youth Services, MRC, OFC, Elder Services, and Solomon Mental Health.

This recommendation is made for several reasons. First, it is the most feasible. Since the ASPT is already functioning, it does not demand the immediate creation of another structure. The board brings a working knowledge of agency and community needs and the center can operate immediately; this allows ample time for outreach efforts to be accomplished by the system's manager, so that consumers and local officials can be identified and recruited.

PHASE II

The work of recruitment is in progress. Local officials and consumers are identified and then appointed by present board members. Appointment avoids the time and cost factors of an election.

Board members can be recruited from several sources. The boards of provider agencies (ASPT) provide one source of interested representatives. Consumers who live in the Southern Tier who participate on agency boards can be enlisted as

members, too. Clients of agencies can be recruited and an advertisement campaign can also recruit board members. Local officials may include state representatives, selectmen and town officials.

During this phase, the systems manager begins to organize Task Forces, advisory groups of consumers and providers organized to work on specific issues or needs. For example, Task Forces might be individually concerned with Transportation Residential Services, Handicapped, Youth, or Elderly.

The board becomes more representative in identifying a broader spectrum of interests. This guarantees better identification of needs and issues. Local officials offer sanction and this further legitimizes the Center.

PHASE III

The terms of some of the members have expired. At this time, the Task Forces have been fully organized. Members from the Task Forces, then, can be recruited to serve as members of the governing board. This assures a board that represents all interests.

7.3 Organizational Structure

THE COLLEGIAL MODEL FOR ORGANIZING CO-LOCATED AGENCIES IS PROPOSED. DIRECT LINE AUTHORITY IS RECOMMENDED FOR PROJECT STAFF.

The systems manager is directly responsible to Governance. The project staff, consisting of a broker and intake/receptionist reports directly to the system's manager.

The system manager, through contractual arrangements, is given limited authority over direct service staff. The contractual arrangements are made between

participating agency directors and the systems manager. The contracts guarantee direct service staff participation in joint staff training and case team diagnosis at the center. Contracts also include designation of specific time that direct staff will give to deliver services at the center. Direct service staff, however, is supervised at the parent agency.

The collegial model provides an appropriate structure for the center since the brokerage system does not demand an elaborate organizational structure. The broker as advocate and evaluator remains unassociated with direct service delivery. The collegial arrangement is also an efficient structure, given the limited allocation of direct service personnel. Day-to-day procedures can be carried out with a minimal amount of turf issues arising.

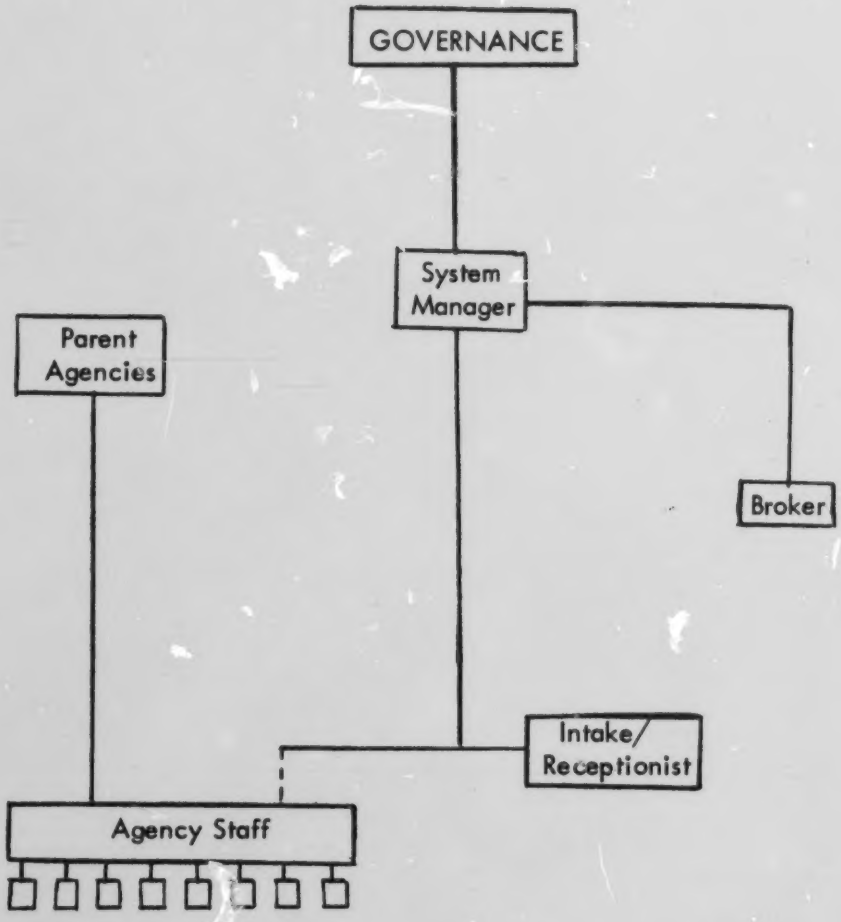
7.4 Staffing Patterns

Phase I

Initially, core staff should be located in the center. Core staff includes a Systems Manager, a Broker, and an Intake/Receptionist. At this time, nominal staff allocation of the center has been made by state agencies. Direct Service Staff, includes:

Solomon Mental Health	2-3 Full Time
Mass. Rehab. Commission	2 Part Time
Mass. Comm. Blind	1 Part Time
Elder Services	1/2 Part Time
MEC	As Needed

A systems analyst consultant is also needed to set up an MIS and an accounting system for Phase II and III.


GOVERNANCE
System Manager
Parent Agencies
Broker
Intake/ Receptionist
Agency Staff

PHASE II

During this phase, more Direct Services staff is allocated to the center because of increased client usage. Solomon sees new future allocations to the mental health staff of 6-8 persons, total. In addition, other agencies transfer staff to meet the needs of their particular populations.

Phase III

Core staff may be increased at this time by an additional broker, since a greater number of clients are using the center.

An increase in the direct service staff occurs. This necessitates the on-site location of agency supervisors.

Core Staff Job Functions

Systems Manager

- Administration of the center's daily operation
- Supervision of core staff
- Arrangement and monitoring of contractual agreements
- Report to Governance
- Discovery and grant writing
- Outreach
- Organization of staff training
- Organization of Task Forces

Qualifications:

- Social Service background with administrative and management skills
- Knowledge of and ability to write grants
- Communication skills
- Leadership qualities

Broker

- Client Advocate
- Follow up
- Approves billing; assumes task of billing
- Assures quality control

Qualifications

- Fiscal and Administrative Skills
- Working knowledge of social service system
- Knowledge of entitlements
- Communication skills

Information/Receptionist

- Provides general information
- Completes initial intake form
- Screens for entitlements
- Clerical and Secretarial tasks

Qualifications:

- Knowledge of the social service system
- Good communication skills
- Clerical and Typing Skills

7.5 Core Services

It is recommended that a shared core service system be insituted. This includes intake, diagnosis, referral, and follow-up. Shared core services allow direct service staff to deliver help without being burdened by indirect service work. It is no longer necessary for the direct service worker to coordinate among other service providers, because the core service staff performs this function.

A common intake limits the client to a single entry experience. This reduces waiting time and red tape and provides a single point for accumulating needs. When individuals enter the system, their needs are recorded, totaled and made immediately available by a computer system. This elminates expensive needs assessments and task force studies.

Common diagnosis reduces duplication of effort by allowing a client to be evaluated only once. An individual does not have to be re-diagnosed at every

agency, so direct service staff can work more efficiently. If a case team is involved, a wide range of expertise, not usually found, becomes available to the client and individual agencies.

Common referral also reduces duplication. One agency treats each specific client's need so that unnecessary services are not given. Shared referral services uncover a wide range of available resources. As well, clients learn where to go if needs have not been fully met. Case coordination is carried out by core service staff, and direct service staff are free to perform treatment. Also, each agency states the type of services it will offer through a contract with the center. Thus, service providers know that clients sent to them are in need of their particular agency's expertise.

A common follow-up insures that the client receives all necessary services. It is hoped that clients leave the system with all needs met. If services have not been satisfactory delivered, the client has convenient access to a single point of accountability. On the other hand, agencies, too, have a place to report needed changes in a service plan--i.e., newly identified needs.

The core services just mentioned are designed to meet the planning concept specifications of a brockerage system. In the actual operation of the system, the client's pathway is shown here. (See Table 7.5).

Client Pathway

The client initially enters and is greeted by an intake person/receptionist. Four types of people usually come to the center; those that do not belong; those who know what they want and where to go; those that have one or two problems but do not know where to go; and those with multiple problems who need help in finding treatment.

The first person is told where he/she should go for services. The next two people are immediately sent to an assigned broker. The last person goes to an interdisciplinary or case team for diagnosis and evaluations, and is subsequently assigned a broker.

Treatment plans are written for all clients. In accordance with the plan, the broker and client contract with individual agencies to provide particular treatment at a specified cost. Intra-agency case management is done by the individual agencies and upon completion of treatment, the agencies notify the broker.

Next the broker meets with the client for a follow-up evaluation. Two events can occur at this point. One is that the treatment has been satisfactory, so payment approval is sent to billing. The other is that treatment has been unsatisfactory. Two alternatives are available to resolve this conflict.

First, the agency agrees with the evaluation and redirects the client; after retreatment, the follow-up process occurs again. Second, the agency believes that it has provided all it can and will not readmit the client. Or, the broker makes the decision to reroute the client through another agency, because he feels that treatment has not been or cannot be well provided. The broker's decision-making power is the backbone of the quality control process, because the initial service provider then is not paid. The competitive spirit motivates agencies to provide the best possible treatment.

Now that the pathway has been described, exact procedures will be explained.

Procedures

Phase I

Intake: A common intake form is designed to record all pertinent information

needed by the ASPT agencies. Background information entitlements and eligibilities are noted by the receptionist/intake person, when a client first enters the system. Client entitlements and other financial resources are recorded on a separate file card and stored for later use. All other information is recorded in duplicate on the data base form. One copy is kept at the intake desk; the other is retained by the client. When needs are easily determined, they are also recorded on the intake form. Clients, in such cases, are then assigned a broker. However, in cases where needs are unknown, a more indepth diagnosis is undertaken.

In Phase I, all records are stored in filing cabinets at the intake desk. The intake person also has easy access to resource directory. Initially, this front desk file system is sufficient, since client load is light. However, as more clients begin to use the center, a new filing system becomes necessary. A systems analyst is hired as a consultant to design and implement an MIS. This new system serves as a resource directory which matches clients and eligibilities with available services. It also stores individual needs information and can categorize those needs into a needs assessment. As such, cumulative backgrounds, past histories, and problems are readily available for planning and programming. Long involved needs assessments are no longer necessary.

Diagnosis: Multiple problem clients require an in depth assessment of their needs. In this phase the intake person makes an appointment for the client to see the case team, which has been organized through contractual agreements between individual agencies and the systems manager. Since, the client load at the center is light at first, a regularly scheduled meeting once every other week should suffice. As time

goes on, however, this may have to change with meetings becoming more frequent. In case of emergencies, the broker will refer client to appropriate services for immediate help.

Once the case team completes the needs portion of the client's data case form, the client is sent back to the intake person who completes the desk intake form copy and then assigns the clients to a broker.

Referral: All referrals are made by the broker. Needs are made known to this person either by the intake person or the case team. Having knowledge of services in the area, the broker meets with the client and explains the alternatives available. Together, they decide which agencies are going to provide the necessary treatments. A contract is then signed by the agency providing the service, the client, and the broker. This contract outlines individual units of service, and specifyies exact costs and services to be provided.

All LASPT agencies provide mandated services. However, these agencies do on occasion contract out for various services; these services, then, are brokered for by the center. Acting on the client's choices, the broker arranges his/her initial appointments. After the initial appointment, the agency providing the service is responsible for meeting the client's specific needs.

Monitoring: Agencies appoint their own case managers. These people assist clients in making and keeping appointments, and generally oversee the client's progress throughout the treatment process. The specifics of a case manager's duty are left up to the individual agencies. At the end of treatment, the case manager reports to the broker that services are completed and at this point, the broker performs the

follow-up function.

Follow-up: The broker interviews the client to determine if the treatment received has been satisfactory. If it has been, specified billing procedures are followed. If treatment has been deemed unsatisfactory, the provider agency is contacted, the problem is discussed, and an arrangement is made as to whether the agency can successfully treat the client. If it can, then the client is asked to return; if not, the client is rerouted to a different agency. This follow-up procedure is followed for all services delivered--until all needs are met or center resources exhausted.

Billing: On completion of satisfactory treatment, the broker authorizes the agency to submit bills for payment. The broker releases the information needed to bill the client (located at the intake desk). The broker then signs or stamps for approval the agency's bill(s). Agreements are with Medicaid, private health insurers, and other financial providers, so that no bills are paid until the broker's signature or stamp appears. The above procedure is necessary, not only to insure quality services, but also to assure that all client needs are met before an agency bills for services rendered. In this way, clients are satisfied that services are responsive to their needs, because no one received payment until client needs are fully met.

Phase II

Intake: During the second phase, the number of clients entering the system increases. The Intake/Receptionist cannot function adequately alone. A screening person is needed to assist in making client entitlements readily known.

This person can be affiliated with a separate billing office or Intake, but since billing becomes a function of the center during this phase, having this person as part of the billing office is appropriate. Now, after entitlements are determined, they are placed on file at the billing office until the broker approves their release.

Also appearing at the beginning of Phase II is an operational MIS. Data base form information can now be immediately recorded into that system. Information that was previously kept on file at the intake desk is now fed into the computer for future needs assessments.

Diagnosis: More frequent case team meetings are necessary. With more clients entering the system, chances are that more multiple problem clients will be seen. These clients have a wide range of problems including marital strife, substance abuse, and various family problems. Evaluating clients in this class takes time, and with more clients seen, more time is needed.

Refferal: Referral is still done by the broker, aided by the operational MIS. Client eligibilities are matched with available services. All services appropriate for individuals are immediately shown to the broker and the client. Once the various services are identified, the client and the broker choose among competing agencies. Contracts are then written, and the client is directed toward the appropriate agency(ies).

Monitoring: Monitoring remains unchanged.

Follow-up: Follow-up remains the same.

Billing: After determining adequate satisfaction, the broker follows the same steps as in Phase I except for two trial agencies. The center now becomes the biller for those two agencies. Since the contracts spell out the costs, no billing from

agency to center is required. The billing office, with the approval of the broker, bills the appropriate source and then pays the appropriate agency, retaining an overhead cost fee for itself.

Now in its second phase, the center's initial grant money expired and it needs additional sources of revenue. One way of receiving them is to charge for indirect services provided. Since this is such a radical change, the two serve as demonstrations. Certain problems will have to be resolved before all agencies are brought into the process but the more agencies that are brought, the greater the economy of scales. This is when, the more one serves, the cheaper the service becomes.

Phase III

Intake: Intake remains the same.

Diagnosis: The case team is becoming overworked, especially if they are still providing direct services. Each member has less time for direct services because of the time required for diagnosis. To deal with this, the center must now hire its own evaluation and diagnostic team. It's sole purpose is to determine individual client needs.

At this time, the center may also want to hire a medical diagnostician for the team. This allows the center to better meet the health needs of clients. Physical problems can be diagnosed as well as mental health needs. Since a special care provider is not represented anywhere in the center, a medical diagnostician would be an asset to the case team.

Referral: Referral remains the same.

Monitoring: Monitoring remains the same.

Follow-up: Follow-up remains the same.

Billing: If the method used in Phase II proves satisfactory, the center becomes the fiscal agent for all the agencies. This offers the center full control over the quality of services, since no payments can be made until satisfactory services are rendered. It also gives the center a viable means for substaining itself without burdening agency budgets. An economy of scale is reached as the center takes on the bill for all participants.

7.6 Planning and Programming

It is recommended that joint planning and programming take place through governance. Two purposes are served. One is to better integrate and coordinate services. The other is to find ways to alleviate gaps in service. A way of determining community wide needs, instead of those for special interest, is presented.

A number of tasks are involved in program planning. These include documentation of needs, identification of gaps in services, designation of programming responsibility, and discovery of funding sources. The documentation of needs and the identification of gaps can be accomplished by clients, the broker, governance, agency personnel, task force, and the systems manager. In time, via a process of common intake with an MIS, needs can be easily documented.

Program responsibility must be assigned to an individual agency and to the center itself, since the center does not act as a direct service provider. Rather, the center is a quality control component of the social service network, as such, it does not provide services but instead, describes weaknesses and helps in strengthening

the total system. As such, the system manager lends technical assistance for the design of programs, the writing of grants, and the discovery of funding sources. The broker model, in order to assure effective advocacy and quality control, insists that the system manager remain outside of direct services provision.

In general, with few exceptions, the planning process involves:

(1) Identificiation of needs; through which
(2) gaps in services are identified; which are then
(3) reported to governance; where
(4) specific agencies are designated as grantee of a program; after which
(5) individual agencies request the technical assistance of the systems manager.

This same process is repeated in all three phases. The difference lies in the methodology of needs determination, outlined as follows:

Phase I

In step one of this process, agency heads have already determined priorities that they bring to governance. Some of these priorities that they bring to governance. Some of these priorities are shared among the agencies (as seen in Chapter VI.) If these priorities require additional service planning, the preceding process is followed. Since no other source of a needs assessment is available at the time, this seems to be the most feasible method of planning. Assigning agencies to different programs allows them to enlarge their service capability and cash flow.

Phase II

The brokerage model provides an important mechanism for determining client needs on an individual basis. As individual needs are cumulated, they become collective needs of the system. When specific needs cannot be met by the system, (that is, when

the broker cannot buy a service) a gap is identified.

The case team evaluction, the broker follow-up, and direct service personnel are also mechanisms for identifying clients' needs. When the internal and external system cannot meet certain needs, gaps are identified to the system manager, and the planning process begins.

During this time, an MIS has been developed and installed for more effective and detailed needs assessment. The MIS, allows documentation and cumulation of individual needs and places them within easy reach of the systems manager.

Phase III

Case teams, the broker, agency personnel, etc., are still sources of information. Now, task forces are in place to advise governance. The task forces talk to community people along with agency and core services personnel. The task forces then report to governance and the planning process commences.

7.7 Funding

It is recommended that the following sources of funding be considered for core services of the multi-service center: 1) Pooled resources; 2) Grants from private foundations; 3) State and Federal funds; and 4) Fee generating services to be paid for either by third party payments or on a sliding fee scale to consumers.

The rationale for these recommendations is based upon the fact that the current source of funds is of a limited duration; when "seed money" is exhausted, it will be necessary to seek out new sources of funding.

Each of the possible funding sources just mentioned has certain benefits to

the center's operation.

(1) Pooled resources from budgets of the participating agencies are beneficial because they have the potential for fostering co-operation and commitment to the center. Using money already in existence, and limiting reliance on Federal funding and the guidelines that often accompany Federal monies, they provide funds for those without financial resources.

(2) Federal and State funding often provides an agency with an available money source that can be easily tapped when service needs of the center coincide with categorical grants available for specific services. The potential exists for agencies to join together in applying for funds to expand their own services.

(3) Fees generated from services is based on client usage of services. It encourages the use of client entitlements in terms of third party payments (Medicaid, Blue Cross, Etc.). As regards the broker system, it insures quality of service based on a competitive system. Finally, it is not restricted by the categorical nature of some of the already mentioned funding sources.

Funding for the center goes through three phases.

Phase I

Initially, the primary source of funding for the multi-service center is from the original "seed money"; this was granted to the ASPT by EOHS for the first year of the center's operation. While the seed money is being used, however, the systems manager must be continually searching for new resources. Since the systems manager is also a grantperson, he/she is looking for both private foundations and State and Federal funding sources. The major function of the system's manager during this phase is to search for grants money to partially cover the cost of the core services during the second phase.

Phase II

During this stage, there is still a dependency on grants, both private and

governmental, but not to the exclusion of pooled resources (which are allocated through individual agency budgets). A newly developed billing system can at this time, be put into operation on a limited basis so the center now has a limited in-house capacity to bill for services. This enables the center to collect a fee for the services it offers, and thus, begins to generate its own financial support.

Phase III

At this point (beginning of the third year of the center's operation) the center has developed an in-house billing system in which the center becomes the fiscal agent for all agencies colocated in the center. Now the center is able to charge a fee for services to the sources being billed. During Phase III, pooled resources also supplement funding and insure the commitment of the various agencies involved at the center.

7.8 Evaluation

It is recommended that an evaluation component which measures the center's ability to meet its objectives be included in the multi-service center design. On-going evaluation is essential for insuring optimal effectiveness and efficiency in the functioning of the center; it also provides a mechanism for determining accountability, client usage, and an assessment of community needs. In order to achieve this, however, the evaluation must measure both the 'product' objectives (in terms of service delivery) and the 'process' objectives (in terms of the center's capacity for co-ordination and integration). In other words, evaluation must measure both program and agency functioning in relation to consumer/client needs.

A well devised system for evaluation can be extremely beneficial for the center in terms of providing a feedback mechanism which gives policy makers and

service providers a constant source of information as regards the center's functioning and its ability to meet the changing needs of the community. It is extremely helpful for the agency to have data which measures performance and can be used to determine which programs should continue, which need modification, and which should be totally discarded. Information gathered through the evaluation process is often necessary in proving program effectiveness when applying for funding, as well as documenting service gaps and indicating areas for future programming.

In terms of the implementation of the evaluation component, it is important to develop an evaluation instrument prior to the center's opening. The instrument must be carefully designed to gather useful information regarding such factors as: 1) Client usage and satisfaction; 2) Degree of integration and co-ordination among agencies involved at the center; 3) Agencies ability to expedite people to necessary service; and 4) the effectiveness of the center in terms of benefits to client and cost involved.

The center's internal system of evaluation will be developed from the specific information gathered from the client at intake. This information is stored in the MIS and is used to provide baseline data for historical analysis, identify target populations, and analyze service needs. As the client proceeds through the system, newly acquired information will be fed into the system.

Upon termination of a case, the case manager (or case team) will submit a summary of services provided by the various agencies to the broker for determination of payment. Before final payment is made, however, the broker and client will meet and evaluate the services rendered, based upon the initial goals of treatment. This information will be fed into the evaluation system where gaps, as well as positive

points, will be recorded for future assessment.

The information submitted by the broker will be analysed on an ongoing basis in terms of the following:

(1) Effectiveness of the center in terms of changes in agency, client, and staff time, and in terms of cost per unit of service;
(2) Increase in services available;
(3) Responsiveness of the organization to service delivery problems;
(4) Clarification of actions taken in response to needs;
(5) Impact of services on client's lives;
(6) Identification of service gaps or community needs; and
(7) Consumer usage in terms of (a) raw information regarding rates of usage, duration in system, etc. and (b) appeal of the center and satisfaction with center's ability to meet specific needs.

As service needs are documented, the information will be submitted to the center's director who, in turn, will make a presentation to the program planners and policy making board. In essence, this evaluation process will assure a continuous needs assessment and evaluation of the center's functioning. Any problems in functioning will be detected early so that corrective adjustments can be made. Accountability will be increased, and the director and board will be well informed concerning the center's operation.

7.9 Conclusion

The elements of the plan for the multi-service center have now been described in detail. Also, the steps for achieving a fully operational center have been delineated. Each element of the plan was discussed in terms of phases. In each phase, certain problems and issues of implementation are anticipated. These issues will be discussed in the next chapter.

* * * * * * * * *

CHAPTER VII: IMPLEMENTATION ISSUES

8.1 Introduction

In the previous chapter, the Planning Lab outlined the planning options for the creation of a multi-service center in the Southern Tier. Since this plan is based on the broker concept, (which is relatively new in terms of social service delivery), it is natural that certain implementation issues surface. The planning lab believes that given an awareness of potential problem areas, the ASPT will be better able to handle issues if and when they arise. The issues to be addressed in this chapter will be relating to the following categories: Governance; Organizational Structure; Staffing Patterns; Core Services; Joint Planning and Programming; Funding; Evaluation; and Community Acceptance.

8.2 Governance

In the plan, governance is discussed in terms of three phases of implementation. Each phase presents issues that must be addressed to make transition to the next phase fluid.

The first phase consists of an all-provider board. A problem encountered with this type of board is that it often becomes self-serving. A second issue relates to representation on the board. If the ASPT assumes the role of governance, authority of representatives issues must be examined. Presently the ASPT is composed of members having varying degrees of authority in their parent agencies. A question that must be answered is: To what degree will the representatives have the authority to speak for their parent agencies? Also, what will the ASPT members represent-their parent agency or the multi-service center?

In the second and third phases, the prime issues will be creating incentives for participation on the board, and assuring that participation is representative of the

community. Recruitment for the task forces is also an issue. Who will be on the task forces and what will they represent?

8.3 Organizational Structure

The collegial model of organization raises two basic issues: 1) the authority of the system's manager, and 2) the strength of voluntary association.

In terms of the system's manager authority, several potential problems can be identified. Because the direct service personnel at the center are ultimately responsible to a supervisor at their parent agency, the system's manager is limited in his ability to intervene in conflict situations; such as, hiring and firing.

In terms of the strength of voluntary association, the collegial model works well only if member agencies shed their agency identifications and work in terms of what is best for the center. The system works through good will. Issues such as unequal pay scales, compensation time and vacation time, etc., among agencies may cause rivalry among direct service staff.

8.4 Staffing Patterns

Presently, there is a limited commitment of direct service staff allocated to the center by member agencies. In the future, as the center's activity increases, an expanded direct service staff will be needed. No guarantee now exists that more staff will be allocated, or that redeployment of staff will be instituted. This is an issue that must be given serious consideration.

Also, as regards the staff to be allocated to the center, there is a potential for a wide range of professionalism among the staff. And another issue is the leadership

quality of the systems manager. To be successful, the system's manager must be an extremely effective and skilled manager.

8.5 Core Services

The issues related to core services functions can be categorized in the following way:

(1) Intake--A basic issue that the center must examine is the method of absorbing clients already being served by the participating agencies into the new system. Also, the data base form to be devised must face the problem of protecting client confidentiality while at the same time, gathering enough information to prevent duplication of the task among agencies involved in the client's case. Finally, the MIS is expensive to initiate, and the cost and time of a consultant must be taken into consideration.

(2) Outreach--Since the multi-service center will be located in new buildings, the issue of informing the community arises. An effective method for communicating the center's existance and functions must be agreed upon by participating agencies.

(3) Diagnosis--An issue that must be faced is the frequency of case team meetings; who should attend? What, if any, are the attendance requirements? As case load increases, these meetings could become very time consuming.

(4) Referral--There is a possibility that resentment may occur if this function is given to the broker alone.

(5) Follow-up--Again, the authority of the broker to determine client satisfaction is an issue to be discussed.

(6) Billing--The most crucial issue in this category is what to do if the client is not satisfied. Also, the center must devise a system for extracting clients in the Southern Tier and billing them separately.

8.6 Joint Programming

In terms of joint programming among ASPT member agencies, several issues must be considered. First, it should be noted that in instances where there is strong

agency identification, efforts at joint programming may be hindered because each agency may seek programs that are self-serving and detrimental to the collective orientation of the center. It may also threaten agency integrity by suggesting that a program is needed to fill a gap that is supposedly already addressed by a participating agency.

Also, the programming component should remain closely linked to an evaluation component in which a feedback mechanism is established. In this way, programs can be continually monitored and their efficiency tested. It is important that programs which have either accomplished their stated goals or no longer serve community needs are not allowed to outlive their usefulness.

In terms of the mechanics of joint programming, each agency may be limited in the degree of flexibility they can offer to the process. Some agency programs may have to follow categorical regulations that are detrimental to the system as a whole.

8.7 Funding

The broker concept for the funding of social service delivery presents a radical transformation from traditional methods. The system represents an undoing of existing patterns of agency funding. A transfer in the purse strings from the individual agencies to the center threatens the lifeline of the individual agencies and may cause disequilibrium in terms of coordination among agencies. Due to the novelty of the system, it may also cause legal entanglements that may require legislative enactments or Federal waivers to implement.

Also since some funding for the direct service functions is to come from pooling of resources, the request for additional allocations from the agencies often places a strain on an agency which is already operating on a limited budget.

8.8 Evaluation

Evaluation, while an essential component in the center, presents problematic issues that must be dealt with if meaningful evaluation is to be achieved. The problem areas can be categorized in terms of two factors: 1) the ability to devise an effective instruemtn of measurement and 2) the quality of service issue.

First, devising an instrument to measure the stated goals and objectives of the multi-service center is extremely difficult. This is partially due to the fact that the instrument must be refined enough to measure specific information, such as service criteria, objectives and performance; yet, at the same time, it must remain flexible enough to adapt to a variety of agency interpretations. Also, the instrument must be devised in such a way that it measures such intangible objectives as client satisfaction, cooperation among agencies, and service integration.

Closely related to these issues is the issue of who is given the authority to evaluate the quality of specific agency functioning. Turf issues may be raised and the director should be prepared to handle possible friction in cases where a client reports to the broker that a specific agency did not meet the goals of the treatment plan.

8.9 Community Acceptance

In order for the center to survive, it is necessary that it be accepted by the residents, clients, and service providers in the Southern Tier. Community support of the center is essential. Issues that effect the degree of support relate to the readiness of the community to accept the center and the willingness of consumers tc change established patterns of receiving services.

The new multi-service center must establish new relationships with other agencies, so the center must enlist their support. Since outside agencies were not involved in the planning process, the center may have to face the issue of possible resentment. Outside agencies may view the center as a possible threat to the existing social service system in the Southern Tier.

8.10 Incorporation vs. Lead Agency

Before one decides whether to incorporate or not, some of the issues should be discussed. Incorporation protects the governing board members from individual liability and allows governance to determine the rules concerning the distribution of its funds. As well, a non-profit corporation is the only entity that can receive a Determination of Need and thereby be licensed to bill and retain profits to develop new programs. On the other hand, incorporation just adds another structure to an already overburdened social service system.

The lead agency concept enables the colloborative to exist without another structure. This agency is designated the funding conduit. The major problem with this method is that all regulations and constraints imposed upon the lead agency's funds are also imposed upon the project's funds.

As of now, the project is designed as a lead agency. It should continue to use Massac husetts Commission for the Blind until the initial grant runs out. As well, Merrimack Education Center has agreed to help out by offering its corporate structure to the ASPT. At the end of the demonstration year, a decision must be made as to which method is going to be used.

8.11 Conclusion

In essence, the plan developed by the Planning Lab is a pilot project and an underestimation of problems is not intended. Any time a change is introduced, it causes reactions among participants. In this case, reactions among participating ASPT agencies are foreseen. By examining the issues critically and working together to seek solutions, however, the Planning Lab contends, that the barriers can be overcome. The plan outlined in this document is based on fundamentally sound concepts and will be beneficial to meeting the needs of the agencies and consumers of the Southern Tier. Moreover, if this plan is successfully implemented, it can be used as a model for future integration efforts. (For change strategies, see Addenda).

* * * * * * * * * *

APPENDICES

A. UWASIS

B. SURVEY OF AGENCIES

C. MISSION ANALYSIS, FUNCTION ANALYSIS, MATRIX OF ELEMENT PHASES

D. CHANGE STRATEGIES

GOAL I: OPTIMAL INCOME SECURITY AND ECONOMIC OPPORTUNITY

A. EMPLOYMENT SERVICE SYSTEM

1. Employment Procurement Services

CETA
DES

2. Employment Training

CETA
LOWELL DIVERSION PROJECT
*DYS

3. Special Employment Services for Exceptional Individuals and Groups (aged, handicapped, and other disadvantaged).

CTI (foster grandparents, neighborhood youth corps)
*MASS. REHAB.
*MASS. COMM. FOR BLIND
EASE, INC.
NATIONAL ALLIANCE OF BUSINESSMEN
MERRIMACK VALLEY GOODWILL INDUSTRIES, INC.
LOWELL INDUSTRIES CENTER

B. INCOME SECURITY SERVICE SYSTEM

1. Social Insurance Service

DES
SSA

2. Financial Aid Service

*DPW

C. INCOME SECURITY AND ECONOMIC OPPORTUNITY SUPPORT SYSTEM

1. Income Security and Economic Opportunity Research and Information Service

NMEC

(* Indicates member agencies of Lowell Area Service Planning Team)

GOAL I: OPTIMAL INCOME SECURITY AND ECONOMIC OPPORTUNITY

A. EMPLOYMENT SERVICE SYSTEM

SYSTEM / SERVICE / AGES	1. EMPLOYMENT PROCUREMENT	2. EMPLOYMENT TRAINING	3. SPECIAL EMPLOYMENT SERVICES FOR EXCEPTIONAL INDIVIDUALS AND GROUPS (AGED, HANDICAPPED, AND OTHER DISADVANTAGED)
0-6			
7-13		LOWELL DIVERSION PROJECT, DYS	
14-21	CETA DES	LOWELL DIVERSION PROJECT, CETA, DYS	CTI, MASS. REHAB. COMMISSION FOR BLIND, EASE, (ex-offenders only), NAT. ALLIANCE OF BUSINESSMEN, M/V GOODWILL INDUSTRIES, LOWELL INDUSTRIAL CENTER
22-59	CETA DES	CETA	CTI, MASS. REHAB. COMMISSION FOR BLIND, EASE, NATIONAL ALLIANCE OF BUSINESSMEN, M/V GOODWILL INDUSTRIES, LOWELL INDUSTRIAL CENTER
60+			CTI-FOSTER GRANDPARENT PROGRAM
ALL AGES			

GOAL I: OPTIMAL INCOME SECURITY

SYSTEM / SERVICE / AGES	B. INCOME SECURITY SERVICE SYSTEM		C. INCOME SECURITY AND ECONOMIC OPPORTUNITY SUPPORT SYSTEM
	1. SOCIAL INSURANCE SERVICE	2. FINANCIAL AID SERVICE	3. INCOME SECURITY AND ECONOMIC OPPORTUNITY AND INFORMATION SERVICE
0-6			
7-13			
14-21	DES		
22-59	DES		
60+	DES		
ALL AGES	SOCIAL SECURITY ADMINISTRATION	DEPARTMENT OF PUBLIC WELFARE	NORTHERN MIDDLESEX AREA COMMISSION

GOAL II: OPTIMAL HEALTH

A. HEALTH MAINTENANCE AND TREATMENT SERVICE SYSTEM

1. COMMUNITY HEALTH MAINTENANCE SERVICE

a. Prevention and control of communicable diseases

Lowell Health Department

Department of Public Health

b. Homemaker-home health assistance

Salvation Army

*Commission for the Blind

Merrimack Valley Home Care Center, Inc.

Family Service of Greater Lowell

*Lowell Elder Services of Merrimack Valley

c. Well-baby

Lowell General Hospital

2. MEDICAL CARE SERVICES

a. Inpatient

Middlesex County Hospital

St. John's Hospital

Veteran's Administration Hospital

Lowell General Hospital

St. Joseph's Hospital, Inc.

b. Outpatient

Department of Public Health

Middlesex County Hospital

Lowell General Hospital

Veteran's Administration Hospital

St. Joseph's Hospital

Lowell Health Department

c. Emergency room medical care

St. Joseph's Hospital

St. John's Hospital

Lowell General Hospital

d. Community care clinic

Family Planning, Inc.

St. John's Hospital

e. Home health care

Lowell Visiting Nurse Association

Lowell Health Department

3. FERTILITY REGULATION SERVICE

Lowell Visiting Nurse Association

St. John's Hospital

Family Planning, Inc.

International Institute

Florence Crittenton League

4. REHABILITATION SERVICE

*Commission for the Blind

Middlesex County Hospital

*Mass. Rehab.

Bay State Rehabilitation and Nursing Care Facility

Easter Seals

Lowell Industrial Center

B. MENTAL HEALTH MAINTENANCE AND TREATMENT SERVICE SYSTEM

1. COMMUNITY MENTAL HEALTH MAINTENANCE SERVICE

a. Alcoholism prevention and treatment

Lowell General Hospital

Middlesex County Hospital

Lowell Alcohol Detox Center

Tewksbury State Hospital

Veteran's Administration Hospital

Share, Inc./Step-One-Share

b. Drug Abuse

Share, Inc./Step-One-Share and Anabasis House

2. MENTAL HEALTH TREATMENT SERVICE

a. Inpatient psychiatric care

Veteran's Administration Hospital

*Solomon Mental Health Center

b. Outpatient psychiatric care

Veteran's Administration

*Solomon Mental Health Center

St. Joseph the Worker Center

Salvation Army

c. Partial hospitalization

*Solomon Mental Health Center

3. CRISIS INTERVENTION AND PROTECTIVE SERVICES

Lowell Visiting Nurses Association

Merrimack Valley Home Care Center

St. John's Hospital

Veteran's Administration Hospital

*Solomon Mental Health Center

Salvation Army

Share, Inc./Step-One-Share

Care and Reach Out

Catholic Charities

Children's Protective Services

Lowell Association for the Blind

*Commission for the Blind

*Department of Public Welfare-Social Services

YMCA/YWCA

Lowell District Court

C. DEVELOPMENTALLY DISABLED ASSISTANCE SERVICE SYSTEM

1. RESIDENTIAL SERVICES FOR MENTAL RETARDATION

Walter E. Fernald State School

GLARC

2. NON-RESIDENTIAL SERVICES FOR MENTAL RETARDATION

Lowell Visiting Nurses Association

*Solomon Mental Health Center

Bay State Rehabilitation and Nursing Care Facility

Holy Union Special School

Retarded Adult Recreation Association

GLARC

D. HEALTH SUPPORT SERVICE SYSTEM

1. HEALTH FINANCIAL AID SERVICES

*Department of Public Welfare

*Division of Child Guardianship

Mass. Department of Public Health, Services for Handicapped Children (Northern Region)

GOAL II: OPTIMAL HEALTH

SYSTEM A. HEALTH MAINTENANCE AND TREATMENT SERVICE SYSTEM

SERVICE / AGES	1. COMMUNITY HEALTH MAINTENANCE SERVICE	2. MEDICAL CARE SERVICE	3. FERTILITY REGULATION SERVICE	4. REHABILITATION SERVICE
0-6				BAY STATE REHAB.
7-13				BAY STATE REHAB.
14-21			VNA, ST. JOHN'S HOSPITAL, INTERNATIONAL INSTITUTE, FAMILY PLANNING, FLORENCE CRITTENTON LEAGUE	BAY STATE REHAB., LOWELL INDUSTRIAL CENTER
22-59	VA HOSPITAL	VA HOSPITAL	SAME AS ABOVE	LOWELL INDUSTRIAL CENTER
60+	M/V HOME CARE CENTER VA HOSPITAL	VA HOSPITAL		
ALL AGES	LOWELL HEALTH DEPT., VNA., COMMISSION FOR BLIND, FAMILY SERVICE OF G. LOWELL, HOSPITALS; St. JOHN'S, St. JOSEPH, LOWELL GENERAL	LOWELL HEALTH DEPT, VNA, MASS. DEPT. OF PUBLIC HEALTH, HOSPITALS; MIDDLESEX, ST. JOHN'S, ST. JOSEPH'S, LOWELL GENERAL		COMMISSION FOR THE BLIND, MIDDLESEX CO., HOSPITAL, EASTER SEALS, MASS. REHAB. SOLOMON MENTAL HEALTH CENTER

GOAL III: OPTIMAL HEALTH

SYSTEM: B. MENTAL HEALTH MAINTENANCE AND TREATMENT SERVICE SYSTEM

SERVICE / AGES	1. COMMUNITY MENTAL HEALTH MAINTENANCE SERVICE	3. CRISIS INTERVENTION/ PROTECTIVE SERVICES	2. MENTAL HEALTH TREATMENT SERVICE
0-6		CHILDREN'S PROTECTIVE SERVICES	HERRMAN SCHOOL
7-13		CARE AND REACH OUT. CHILDREN'S PROTECTIVE SERVICES, DPW	HERRMAN SCHOOL, SHARE, INC/OASIS
14-21	LOWELL HOUSE, MASS REHAB.	CARE AND REACH OUT, CHILDREN'S PROTECTIVE SERVICES, DPW	HERRMAN SCHOOL, SHARE, INC./ OASIS AND ANABASIS HOUSE
22-59	VA HOSPITAL, LOWELL HOUSE, MASS. REHAB.	VA HOSPITAL, CARE AND REACH OUT	VA HOSPITAL, SHARE, INC./ANABASIS HOUSE
60+	VA HOSPITAL, LOWELL HOUSE, MASS. REHAB.	M/V HOME CARE CENTER, VA HOSPITAL, CARE AND REACH OUT	VA HOSPITAL
ALL AGES	LOWELL ALCOHOL DETOX, VNA, MENTAL HEALTH ASSOCIATION, MIDDLESEX CO. HOSPITAL, LOWELL GENERAL HOSPITAL, SOLOMON MENTAL HEALTH ASSOC. FOR MENTALLY ILL CHILDREN, SHARE, STEP-ONE-SHARE, SALVATION ARMY, TEWKS. STATE HOSP., ST. JOS. THE WORKER CTR.	VNA, ST. JOHN'S HOSP., SOLOMON, SALVATION ARMY, CATHOLIC CHARITIES, ASSOC. FOR BLIND, COMM. FOR BLIND, YMCA, YWCA, LOWELL DISTRICT COURT, SHARE, INC./ONE-STEP-SHARE	SOLOMON MENTAL HEALTH CENTER, MIDDLESEX COUNTY HOSPITAL, LOWELL GENERAL HOSPITAL

GOAL II: OPTIMAL HEALTH

SYSTEM / SERVICE / AGES	C. DEVELOPMENTALLY DISABLED ASSISTANCE SERVICE SYSTEM		D. HEALTH SUPPORT SERVICE SYSTEM
	1. RESIDENTIAL SERVICES FOR MENTALLY RETARDED	2. NON-RESIDENTIAL SERVICES FOR MENTALLY RETARDED	1. HEALTH FINANCIAL AID SERVICES
0-6		BAY STATE REHAB/NURSING CARE FACILITY, HOLY UNION SPECIAL SCHOOL	DPW, DEPT. OF PUBLIC HEALTH/ SERVICES FOR HANDICAPPED CHILDREN
7-13		BAY STATE REHAB/NURSING CARE FACILITY, HOLY UNION SPECIAL SCHOOL	DPW, DEPT. OF PUBLIC HEALTH/ SERVICES FOR HANDICAPPED CHILDREN
14-21		BAY STATE REHAB., HOLY UNION SPECIAL SCHOOL, RETARDED ADULT RECREATION ASSOCIATION	DPW, DEPT. OF PUBLIC HEALTH/ SERVICES FOR HANDICAPPED CHILDREN
22-59		RETARDED ADULT RECREATION ASSOCIATION	
60+		RETARDED ADULT RECREATION ASSOCIATION	
ALL AGES	WALTER E. FERNALD SCHOOL	LOWELL VNA, SOLOMON MENTAL HEALTH CENTER, GLARC	DEPARTMENT OF PUBLIC WELFARE

GOAL III: BASIC NEEDS AND COLLECTIVE SAFETY

A. FOOD AND NUTRITION SERVICES SYSTEM

1. GOVERNMENT FOOD SUBVENTION AND ASSISTANCE SERVICE

Food Stamp

*DPW

2. VOLUNTARY FOOD SERVICE

Merrimack Valley Home Care Center

Council on Aging

3. EMERGENCY FOOD SERVICE

Red Cross

B. CLOTHING SERVICES SYSTEM

1. SUBSIDIZED OR FREE APPAREL

Red Cross

Salvation Army

C. HOUSING SERVICES SYSTEM

1. URBAN RENEWAL

Office of City Manager-Division of Planning & Development

2. HOUSING SUBVENTION

Community Teamwork Inc.

Local Housing Authority

3. GENERAL HOUSING SEARCH

International Institute

4. EMERGENCY SHELTER

Red Cross

D. TRANSPORTATION SERVICE SYSTEM

1. SPECIAL TRANSPORTATION SERVICES FOR SELECTED GROUPS

a. Blind

Lowell Association for the Blind

b. Elderly

CTI

M/V Home Care Services

c. Emergency

d. Handicapped (physical and mental)

Mental Health Association of Lowell

Premature Parent Program

March of Dimes

e. Medical

Florence Crittenton League

M/V Right to Life

American Cancer Association

Muscular Dystrophy Association

E. PUBLIC PROTECTION, JUSTICE AND SAFETY SERVICES SYSTEM

1. CONSUMER PROTECTION SERVICES

Town Action Committees

Office of Consumer Affairs

2. LEGAL AID AND PUBLIC DEFENDER SERVICES

*Lowell Elder Services of M/V

Lawyer Referral System

Mass. Defenders Committee

M/V Legal Services

Children's Protective Services

Florence Crittenton League

3. CRIME AND DELINQUENCY PREVENTION SERVICES

Lowell Diversion Project

Boy Scouts

YMCA/YWCA

4. ADMINISTRATION OF JUSTICE SERVICE

Police Department

*DYS

GOAL III: BASIC NEEDS AND COLLECTIVE SAFETY

SYSTEM / SERVICE / AGES	A. FOOD AND NUTRITIONAL SERVICE SYSTEM			B. CLOTHING SERVICES SYSTEM
	1. GOVERNMENT FOOD SUBVENTION ASSIST.	2. VOLUNTARY FOOD SERVICE	3. EMERGENCY FOOD SERVICE	1. SUBSIDIZED OR FREE APPAREL SERVICE
0-6				
7-13				
14-21				
22-59				
60+		MERRIMACK VALLEY HOME CARE, COUNCIL ON AGING		
ALL AGES	FOOD STAMPS, DPW		RED CROSS	RED CROSS, SALVATION ARMY

GOAL III: BASIC NEEDS

SYSTEM C. HOUSING SERVICE SYSTEM

SERVICE / AGES	1. URBAN RENEWAL	2. HOUSING SUBVENTION	3. GENERAL HOUSING SEARCH	4. EMERGENCY SHELTER (burn outs, disaster, etc.)
0-6				
7-13				
14-21				
22-59				
60+				
ALL AGES	OFFICE OF CITY MANAGER DIVISION OF PLANNING (no direct service)	CTI, LOCAL HOUSING AUTHORITY	INTERNATIONAL INSTITUTE	RED CROSS

SYSTEM D. TRANSPORTATION SERVICE SYSTEM

SERVICE / AGES	1. SPECIAL TRANSPORTATION SERVICES FOR SELECT GROUPS			
	d. HANDICAPPED	e. MEDICAL RELATED	c. EMERGENCY	b. SELECT GROUP
0-6	MARCH OF DIMES			
7-13	MARCH OF DIMES			
14-21	PREMATURE PARENT PROGRAM (MHA) MARCH OF DIMES	MERRIMACK VALLEY RIGHT TO LIFE		
22-59	PREMATURE PARENT PROGRAM	M/V RIGHT TO LIFE		
60+				MERRIMACK VALLEY HOME CARE, CTI
ALL AGES	MENTAL HEALTH ASSOCIATION OF GREATER LOWELL, ASSOCIATION FOR BLIND	AMERICAN CANCER SOCIETY, MUSCULAR DYSTROPHY ASSOCIATION		

GOAL III: BASIC NEEDS

SYSTEM E. PUBLIC PROTECTION, JUSTICE, AND SAFETY SERVICES SYSTEM

SERVICE / AGES	1. CONSUMER PROTECTION	2. LEGAL AID AND PUBLIC DEFENDER	3. CRIME AND DELINQUENCY PREVENTION	4. ADMINISTRATION OF JUSTICE
0-6				
7-13			YMCA, YWCA, BOY SCOUTS	DYS
14-21		MASS. DEFENDERS COMMITTEE FLORENCE CRITTENTON LEAGUE	LOWELL DIVERSION PROJECT, BOY SCOUTS, YMCA, YWCA	DYS
22-59		MASS DEFENDERS, FLORENCE CRITTENTON LEAGUE	LOWELL DIVERSION PROJECT	
60+		MASS. DEFENDERS, LOWELL ELDER SERVICES OF MERRIMACK VALLEY		
ALL AGES	TOWN ACTION COMMITTEE, OFFICE OF CONSUMER AFFAIRS	LAWYER REFERRAL SYSTEM, LEGAL AID, M/V LEGAL SERVICES		POLICE DEPARTMENT

GOAL IV: OPTIMAL OPPORTUNITY FOR AQUISITION OF KNOWLEDGE AND SKILLS

A. FORMAL EDUCATION SERVICE SYSTEM

1. PRE-SCHOOL SERVICES

Early Childhood Development Team

Lowell Day Nursery

Pre-school Class for the Deaf (Dept. of Ed.)

United Cerebral Palsy Association

2. ELEMENTARY SERVICES

Public Schools

*DYS

3. SECONDARY SCHOOL SERVICES

Public Schools

*DYS

4. HIGHER EDUCATION SERVICES

B. INFORMAL AND SUPPLEMENTARY SERVICES SYSTEM

1. INFORMAL EDUCATION SERVICES

Lowell Area Council on Inter-library Networks

Libraries

2. SUPPLEMENTARY EDUCATIONAL SERVICES

International Institute

Lowell Cooperative Learning Center

*MEC

Middlesex County Extension Service

YMCA/YWCA

Lowell Boys Club

3. SPECIAL EDUCATION SERVICES FOR THE GIFTED AND DISADVANTAGED

GLARC

Lowell Boys Club

Lowell Diversion Project

Holy Union Special School

*MEC

United Cerebral Palsy

Herrman School

*Mass. Commission for Blind

GOAL IV: OPTIMAL OPPORTUNITY FOR AQUISITION OF KNOWLEDGE AND SKILLS

SYSTEM / SERVICE / AGES	A. FORMAL EDUCATION		B. INFORMAL EDUCATION AND SUPPLEMENTARY EDUCATION		
	1 and 2. PRE-SCHOOL	3 and 4. ELEMENTARY AND SECONDARY AND HIGHER ED.	1. INFORMAL EDUCATION	2. SUPPLEMENTAL EDUCATION	3. SPECIAL EDUCATION FOR GIFTED AND DISADVANTAGED
0-6	EARLY CHILDHOOD DEVELOPMENT TEAM, LOWELL DAY NURS. PRE-SCHOOL CLASS FOR DEAF, UNITED CEREBRAL PALSY				MEC, HERRMAN SCHOOL HOLY UNION SPECIAL SCHOOL
7-13		PUBLIC SCHOOL DYS		YMCA, YWCA, BOYS (GIRLS) CLUB	BOYS (GIRLS) CLUB. LOWELL DIVERSION PROJ. MEC, HERRMAN SCHOOL, HOLY UNION SPEC. SCHOOL
14-21		PUBLIC SCHOOL DYS		LOWELL COOPERATIVE LEARNING CENTER, YMCA, YWCA, BOYS (GIRLS) CLUB	LOWELL BOYS (GIRLS)CLUB LOWELL DIVERSION PROJ. MEC, HERRMAN SCHOOL, HOLY UNION SPEC. SCHOOL
22-59				LEARNING COOPERATIVE LEARNING CENTER, YMCA, YWCA	
60+				LOWELL COOPERATIVE LEARNING CENTER, YMCA, YWCA	
ALL AGES			LOWELL AREA COUNCIL ON INTER-LIBRARY NETWORKS, LIBRARIES	MEC, INTERNATIONAL INSTIT. ARTHRITIS AND RHEUMATISM, MIDDLESEX COUNTY EXTEN. SERVICE	GLARC, MASS. COMM. FOR THE BLIND, UNITED CEREBRAL PALSY

GOAL V: OPTIMAL SOCIAL FUNCTIONING

A. INDIVIDUAL AND FAMILY LIFE SERVICE SYSTEM

1. FAMILY PRESERVATION AND STRENGTHENING SERVICE

a. Counseling:

1. General

Care and Reach Out

Dignity

Ecumenical Counseling Service, Inc.

Greater Lowell Pastoral Center

Lowell Health Department

Lowell Visiting Nurse Association

Department of Mental Health

St. Joseph's Hospital

St. Joseph the Worker Center

Salvation Army

Share, Inc.

YMCA/YWCA

2. For persons with a mental or physical disability

Epilepsy Society of Mass.

Lowell Association for the Blind

GLARC

*Commission for the Blind

*DMH

Arthritis and Rheumatism Foundation

Easter Seals

March of Dimes

Cerebral Palsy

*Mass. Rehab.

Counseling

3. Family and marital

   Care and Reach Out

   Catholic Charities

   Child Protective Services

   Family Services of Greater Lowell

   *DMH

   St. Joseph the Worker Center

4. Pregnancy and unwed mothers

   Care and Reach Out

   Florence Crittenton League

   Merrimack Valley Right to Life

   Catholic Charities

5. Vocational

   Lowell-Woburn Diversion Project-Adults

   Share, Inc.

6. Alcohol and substance abuse

   Greater Lowell Council on Alcoholism

   Alanon

   Lowell Alcoholism Detox Center

   Lowell General Hospital

   Middlesex County Hospital

7. Elderly

   *Lowell Elder Services of Merrimack Valley

   Merrimack Valley Home Care Center

8. Immigrants

   International Institute

   Immigration and Americanization Dept.

Counseling

9. Corrections and ex-offenders

Ease, Inc.

Lowell Diversion Project

Mass. Defenders Committee

Community Advancement Program

*DYS

*DPW-Office of Social Services

10. Youth

Share, Inc./Morningstar

Herrman School

Children's Protective Services of Mass.

Lowell Diversion Project

Middlesex County Extension Service

11. Single parent family development

Parents Without Partners

B. FAMILY SUBSTITUTE/FOSTER CARE SERVICE

Care and Reach Out

Catholic Charities

Florence Crittenton League

Lowell Association for the Blind

Lowell House-Alcohol Halfway House

Share, Inc.-Anabasis House

Salvation Army (emergency shelter)

*DYS

C. FAMILY SUPPLEMENTING SERVICE

Retarded Adult Recreation Association of Greater Lowell

YMCA/YWCA

Lowell Day Nursery

Salvation Army

B. SOCIAL GROUP ADJUSTMENT AND DEVELOPMENT SERVICE SYSTEM

1. RECREATIONAL SERVICES

Boys/Girls Scouts

Camp Fire Girls

Camp Paul

Catholic Charities

Lowell Association for the Blind

Boys/Girls Club

Middlesex County Extension

Retarded Adult Recreation Association

YMCA/YWCA

Epilepsy Foundation

Department of Recreation

2. SOCIAL GROUP ADJUSTMENT

AA

Alateen

Alanon

Gamon

Community Advancement Program

Lowell Association for the Blind

Premature Parenthood/MHA

National Foundation for Sudden Infant Death

Parents Without Partners

Dignity

Cerebral Palsy

3. AUXILIARY SOCIAL SERVICES FOR INDIVIDUALS AND FAMILIES

*Elder Services for Merrimack Valley

Big Brother/Big Sister

GOAL V: OPTIMAL SOCIAL FUNCTIONING

SYSTEM A. INDIVIDUAL AND FAMILY LIFE SERVICE SYSTEM

SERVICE / AGES

1. FAMILY PRESERVATION AND STRENGTHENING SERVICES (COUNSELING)

AGES	5. VOCATIONAL	8. IMMIGRANTS	6. ALCOHOL & DRUG	9. CORRECTIONS	7&10. AGE SPECIFIC
0-6					DPW/OFFICE OF SOCIAL SERVICES/PROTECTIVE SERVICES
7-13				COMMUNITY ADVANCEMENT PROGRAM, DYS	DPW/SOCIAL SERVICES/ PROTECTIVE SERVICES/ HERRMAN SCHOOL
14-21	LOWELL DIVERSION PEOJECT, SHARE/ ANABASIS HOUSE		ALANON	EASE, INC. LOWELL DIVERSION PROJECT, MASS. DEFENDERS COMM. COMMUNITY ADVANCEMENT PROGRAM. DYS	SHARE/MORNINGSTAR/ DPW/SOCIAL SERVICES/ PROTECTIVE SERVICES/ LOWELL DIVERSION PROJ. HERRMAN SCHOOL
22-59	WOBURN DIVERSION PROJECT, SHARE/ ANABASIS HOUSE		ALANON	EASE INC.. MASS. DEFENDERS COMMITTEE	
60+			ALANON	EASE INC., MASS. DEFENDERS COMMITTEE	ELDER SERVICES OF M/V, M/V HOME CARE CENTER
ALL AGES		INTERNATIONAL INSTITUTE, IMMIGR. AND AMERICANIZATION DEPT.	GR. LOWELL COUNCIL ON ALCOHOLISM, LOWELL DETOX CTR.. LOWELL GENERAL HOSP. MIDDLESEX COUNTY HOSPITAL		MIDDLESEX COUNTY EXTENSION SERVICE

V. OPTIMAL SOCIAL FUNCTIONING

SYSTEM INDIVIDUAL AND FAMILY LIFE SERVICE SYSTEM

SERVICE / AGES	FAMILY PRESERVATION AND STRENGTHENING SERVICES (COUNSELING)			
	3. FAMILY AND MARITAL	4. PREGNANCY & UNWED	2. MENTAL & PHYSICAL	1. GENERAL
0-6	CHILDREN'S PROTECTIVE SERVICES			
7-13	CHILDREN'S PROTECTIVE SERVICES			
14-21	CHILDREN'S PROTECTIVE SERVICES, CARE AND REACH OUT	*CARE AND REACH OUT, FLORENCE CRITTENTON LEAGUE, M/V RIGHT TO LIFE, CATHOLIC CHARITIES		CARE AND REACH OUT, ECUMENICAL COUNSELING, INC.
22-59	CARE ABD REACH OUT.			CARE AND REACH OUT, ECUMENICAL COUNSELING. INC.
60+	CARE AND REACH OUT			CARE AND REACH OUT, ECUMENICAL COUNSELING, INC,
ALL AGES	CATHOLIC CHARITIES, FAMILY SERVICES OF GREATER LOWELL, ST. JOSEPH THE WORKER CENTER, DPW		EPILEPSY SOCIETY, ASSN. OF BLIND, GLARC, DMH, COMM. FOR BLIND, ARTHRITIS AND RHEUMATISM FOUNDATION, EASTER SEALS, MARCH OF DIMES, CEREBRAL PALSY	DIGNITY (Gays), GR. LOWELL PASTORAL CENTER, HEALTH DEPT. VNA, ST. JOSEPH THE WORKER CENTER. SALVATION ARMY, SHARE, INC, YMCA. YWCA, ST. JOSEPH HOSPITAL

GOAL V: OPTIMAL SOCIAL FUNCTIONING

SYSTEM: INDIVIDUAL AND FAMILY LIFE SERVICE SYSTEM

AGES \ SERVICE	b. FAMILY SUBSTITUTE/FOSTER CARE SERVICES	C. FAMILY SUPPLEMENTING SERVICES
0-6	DPW/SOCIAL SERVICES GUARDIANSHIP	LOWELL DAY NURSERY
7-13	DPW/SOCIAL SERVICES GUARDIANSHIP, DYS	YMCA, YWCA
14-21	CARE AND REACH OUT, FLORENCE CRITTENTON LEAGUE, DPW/SOCIAL SERVICES AND DIVISION OF CHILD GUARDIANSHIP, SHARE INC./ANABASIS HOUSE, DYS	RETARDED ADULT RECREATION ASSOCIATION YMCA, YWCA
22-59	CARE AND REACH OUT, FLORENCE CRITTENTON LEAGUE, SHARE, INC./ANABASIS HOUSE	RETARDED ADULT RECREATION ASSOCIATION, YMCA, YWCA
60+	CARE AND REACH OUT	RETARDED ADULT RECREATION ASSOCIATION YWCA, YMCA
ALL AGES	CATHOLIC CHARITIES, LOWELL ASSOCIATION FOR BLIND. LOWELL HOUSE, SALVATION ARMY (emergency shelter).	SALVATION ARMY

GOAL V: OPTIMAL SOCIAL FUNCTIONING

SYSTEM B. SOCIAL GROUP ADJUSTMENT AND DEVELOPMENT SERVICE SYSTEM

SERVICE / AGES	1. RECREATION	2. SOCIAL GROUP ADJUSTMENT	3. AUXILIARY SOCIAL SERVICES FOR GROUP AND INDIVIDUAL
0-6	CAMP FIRE GIRLS, CAMP PAUL, CATHOLIC CHARITIES, BOYS/GIRLS CLUB	DEPARTMENT OF RECREATION, COMMUNITY ADVANCEMENT PROGRAM	
7-13	BOYS/GIRLS SCOUTS, CAMP FIRE GIRLS, CAMP PAUL, CATHOLIC CHARITIES, BOYS/GIRLS CLUB. YMCA, YWCA,	DEPARTMENT OF RECREATION ALATEEN, COMMUNITY ADVANCEMENT PROGRAM	BIG BROTHER BIG SISTER
14-21	BOYS/GIRLS SCOUTS, CAMP FIRE GIRLS, CAMP PAUL, CATHOLIC CHARITIES, BOYS/GIRLS CLUB, YMCA, YWCA, RETARDED ADULTS RECREATION ASSOCIATION	AA, AL -TEEN. ALANON, GAMON, DIGNITY. (gays only). COMMUNITY ADVANCEMENT PRO., PREMATURE PARENT-HOOD/MHA, NATIONAL FOUNDATION FOR SUDDEN INFANT DEATH, PARENT W/O PARTNERS	BIG BROTHER BIG SISTER
22-59	RETARDED ADULT RECREATION ASSOC. YMCA, YWCA	AA, ALANON, GAMON, PREMATURE PARENTHOOD/MHA, NATIONAL FOUNDATION FOR SUDDEN INFANT DEATH, PARENTS W/O PARTNERS, DIGNITY	
60+	RETARDED ADULT RECREATION ASSOCIATION, YMCA. YWCA	AA, ALANON, GAMON, DIGNITY	ELDER SERVICES OF MERRIMACK VALLEY
ALL AGES	LOWELL ASSOCIATION FOR BLIND, EPILEPSY FOUNDATION, MIDDLESEX COUNTY EXTENSION SERVICE	LOWELL ASSOCIATION FOR THE BLIND, CEREBRAL PALSY	

GOAL VI: ADEQUATELY ORGANIZED SOCIAL INSTRUMENTALITIES

A. MOBILIZATION OF PEOPLE SERVICE SYSTEM

1. SOCIAL AND COMMUNITY ORGANIZATION SERVICES

a. Advocacy

Association for Mentally ill children

CTI

Mass. Assoc. for Mental Health

MARC/GLARC

Mass. Defenders Committee

Council for Children

YMCA

Easter Seals

b. Community Organizing

Greater Lowell Council on Alcoholism

Mass. Defenders Committee

*Mass. DMH

Retarded Adult Recreational Association

Mental Health Association of Greater Lowell

B. RESOURCE DEVELOPMENT SERVICE SYSTEM

1. HUMAN SERVICE PROGRAMS FUNDING SERVICES

M/V United Fund, Inc.

Association for Mentally Ill Children

2. SOCIAL AND ECONOMIC DEVELOPMENT SERVICES

NMAC

*OFC

Human Service Corporation

City Development Authority

C. ADMINISTRATION AND MANAGEMENT CAPABILITIES SERVICE SYSTEM

1. ADMINISTRATION SERVICES

MARC

*DMH

M/V Health Planning, Inc.

City Development Authority

Council for Children

2. COMMUNITY AND PUBLIC INFORMATION SERVICES

Association for Mentally Ill Children

Ease, Inc.

Epilepsy Society

MARC/GLARC

Lowell Council on Alcoholism

Greater Lowell Pastoral Counseling Center

LACOIN-WLTI-FM

Mass. Assoc. for Children With Learning Disabilities

*Mass. DMH

Mental Health Association of Greater Lowell

United Fund

*Premature Parenthood-DMH

Mass. Assoc. for Mental Health

American Cancer Society

March of Dimes

National Foundation for Ileitis and Colitis

*Solomon Mental Health Center

National Multiple Sclerosis Society

National Foundation for Sudden Infant Death

Lowell District Court (Speakers Bureau)

Heart Association

3. CLEARINGHOUSE

*MEC

*Solomon Center

MARC

Health Planning Council

4. INFORMATION & REFERRAL SERVICES (separately organized)

Florence Crittenton League

MARC/GLARC

Lowell Council on Alcoholism

International Institute

Lawyer Referral Service

Lowell Association for the Blind

Lowell Health Department

Lowell Housing Authority

Lowell VNA

*Mass. Commission for the Blind

Mental Health Association for Greater Lowell

M/V Home Care Center

United Fund

Muscular Dystrophy Association

St. John's Hospital (medical only)

Salvation Army

Share. Inc.

*Solomon Center

Immigration & Americanization Department

Red Cross

Heart Fund

Easter Seals

*Lowell Elder Services of MV

March of Dimes

Lowell District Court

Cerebral Palsy

Middlesex Resp. Disease Association

5. RESEARCH SERVICES

Council for Children

Human Services Corporation

M/V Health Planning Council

American Cancer Society

Arthritis and Rheumatism

March of Dimes

National Foundation for Ileitis and Colitis

National Multiple Sclerosis Society

Middlesex Respiratory Disease Association

GOAL:

SYSTEM / SERVICE / AGES	A. MOBILIZATION OF PEOPLE SERVICE SYSTEM		B. RESOURCE DEVELOPMENT SERVICE SYSTEM	
	1. SOCIAL AND COMMUNITY ORGANIZATION SERVICES		1. HUMAN SERVICE PROGRAMS FUNDING SERVICES	2. SOCIAL AND ECONOMIC DEVELOPMENT SERVICES
	a. ADVOCACY	b. COMMUNITY ORGANIZATION		
0-6	ASSOCIATION FOR MENTALLY ILL CHILDREN, COUNCIL FOR CHILDREN		ASSOCIATION FOR MENTALLY ILL CHILDREN	OFFICE FOR CHILDREN
7-13	ASSOCIATION FOR MENTALLY ILL CHILDREN, COUNCIL FOR CHILDREN		ASSOCIATION FOR MENTALLY ILL CHILFEN	OFFICE FOR CHILDREN
14-21	ASSOCIATION FOR MENTALLY ILL CHILDREN, MASS. DEFENDER COMMITTEE, COUNCIL FOR CHILDREN	MASS. DEFENDERS COMM. RETARDED ADULT RECREATION ASSOCIATION	ASSOCIATION FOR MENTALLY ILL CHILDREN	OFFICE FOR CHILDREN
22-59	MASS, DEFENDERS COMM., YWCA	MASS DEFENDERS COMM. RETARDED ADULT REC. ASSOCIATION		
60+	MASS. DEFENDERS COMM., YWCA	MASS. DEFENDERS COMM. RETARDED ADULT REC. ASSOCIATION		
ALL AGES	CTI, MASS. ASSOC. FOR MENTAL HEALTH, GLARC/MARC EASTER SEALS	GR. LOWELL COUNCIL ON ALCOHOLISM, MASS. DMH, MENTAL HEALTH ASSOC. OF GR. LOWELL	M/V UNITED FUND, INC.	NMAC, HUMAN SERVICES CORP., CITY DEVELOPMENT AUTHORITY

GOALS VI: ADEQUATELY ORGANIZED SOCIAL INSTRUMENTALITIES

SYSTEM C. ADMINISTRATION AND MANAGEMENT CAPABILITIES SERVICE SYSTEM

SERVICE / AGES	1. ADMINISTRATION SERVICES	5. RESEARCH SERVICES
0-6	COUNCIL FOR CHILDREN	COUNCIL FOR CHILDREN
7-13	COUNCIL FOR CHILDREN	COUNCIL FOR CHILDREN
14-21	COUNCIL FOR CHILDREN	COUNCIL FOR CHILDREN
22-59		C
60+		
ALL AGES	MARC, DMH, M/V HEALTH PLANNING, INC. CITY DEVELOPMENT AUTHORITY	HUMAN SERVICES CORP., M/V HEALTH PLANNING COUNCIL, AMERICAN CANCER SOCIETY, ARTHRITIS AND RHEUMATISM FOUNDATION, MARCH OF DIMES, NATIONAL FOUNDATION FOR ILEITIS AND COLITIS, NATIONAL MULTIPLE SCLEROSIS SOCIETY, MIDDLESEX RESPIRATORY DISEASE ASSOCIATION

SYSTEM: C. ADMINISTRATION AND MANAGEMENT CAPABILITIES SERVICE SYSTEM

SERVICE / AGES	2. COMMUNITY AND PUBLIC INFORMATION SERVICES
0-6	ASSOCIATION FOR MENTALLY ILL CHILDREN, MASS. ASSOC. FOR CHILDREN WITH LEARNING DISABILITIES,
7-13	ASSOCIATION FOR MENTALLY ILL CHILDREN, MASS. ASSOC. FOR CHILDREN WITH LEARNING DISABILITIES,
14-21	ASSOCIATION FOR MENTALLY ILL CHILDREN, EASE INC., GR. LOWELL PASTORAL COUNSELING CENTER, MASS. ASSOCIATION FOR CHILDREN WITH LEARNING DISABILITIES, PREMATURE PARENTHOOD/AMH, MEC,
22-59	EASE INC., GR. LOWELL PASTORAL COUNSELING CENTER, PREMATURE PARENTHOOD/AMH,
60+	EASE INC., GR. LOWELL PASTORAL COUNSELING CENTER,
ALL AGES	EPILEPSY SOCIETY, GLARC/MARC, LACOIN-WLTI-FM, MASS. DMH, MENTAL HEALTH ASSOC. OF GR. LOWELL, UNITED FUND, MASS. ASSOC. FOR MENTAL HEALTH, AMERICAN CANCER SOCIETY, MARCH OF DIMES, NAT. FOUNDATION FOR ILEITIS AND COLITIS, SOLOMON MENTAL HEALTH CENTER, NATIONAL MULTIPLE SCLEROSIS SOCIETY, NAT. FOUNDATION FOR SUDDEN INFANT DEATH, LOWELL DISTRICT COURT (SPEAKERS BUREAU) HEART ASSOCIATION, CLEARINGHOUSE: SOLOMON CENTER, MEC, HEALTH PLANNING COUNCIL

GOALS VI: ADEQUATELY ORGANIZED SOCIAL INSTRUMENTALITIES

SYSTEM: ADMINISTRATION AND MANAGEMENT CAPABILITIES SERVICE SYSTEM

SERVICE / AGES	4. INFORMATION AND REFERRAL SERVICES (separately organized)
0-6	
7-13	
14-21	FLORENCE CRITTENTON LEAGUE
22-59	FLORENCE CRITTENTON LEAGUE
60+	M/V HOME CARE CENTER
ALL AGES	GLARC/MARC, LOWELL COUNCIL ON ALCOHOLISM, INTERNATIONAL INSTITUTE, LAWYER REFERRAL SERVICE, LOWELL ASSOC. FOR THE BLIND, LOWELL HEALTH DEPARTMENT, LOWELL HOUSING AUTHORITY, LOWELL VNA, MASS. COMM. FOR THE BLIND, MENTAL HEALTH ASSOC., OF GREATER LOWELL, UNITED FUND INC, MUSCULAR DYSTROPHY ASSOC., ST. JOHN'S HOSPITAL (medical only), SALVATION ARMY, SHARE INC., SOLOMON CENTER, IMMIGRATION AND AMERICANIZATION DEPT., RED CROSS, EASTER SEALS, MARCH OF DIMES, HEART ASSOCIATION, LOWELL DISTRICT COURT, UNITED CEREBRAL PALSY ASSOC. MIDDLESEX RESPIRATORY DISEASE ASSOCIATION

AGENCY SURVEY QUESTIONNAIRE

NAME OF AGENCY_____DIRECTOR_____

ADDRESS_____

TELEPHONE_____

CONTACT PERSON_____

POSITION_____

PRIORITIES

1. Using the EOHS Taxonomy, what are the top four service priorities of your agency to be administered from the multi purpose center?

1._____

2._____

3._____

4._____

2. How were your priorities determined? _____

_____

_____

_____

_____

3. Do you perceive any major changes in these service priorities in the next five years? Yes_____ No_____

If yes, how? _____

_____

_____

_____

4. Do you have any direct service programs located in the four towns?

_____

_____

5. What staff could you allocate to a multi service center?

Amount of time allocated

6. Describe your organizational structure. Provide charts, and include description of citizen or advisory board.

FUNDING

7. Please list source of funding.

SERVICE	SOURCE	% OF TOTAL

8. In order to provide services in a multi service center, list possible future sources of funding.

_____

_____

_____

_____

9. Do you purchase service from any other agencies? If yes, please list.

SERVICE	AGENCY	AMOUNT

10. Does any other agency purchase services from you? If yes, please list.

SERVICE	AGENCY	AMOUNT

11. Please provide service characteristics information on chart on next page. Use the following Age Group, Target Population, and Geographical Area classifications:

AGE GROUP	TARGET POPULATION	GEOGRAPHICAL AREA
A-0-6	F- Single Parent Households	B- Billerica
B-7-13	G- Mentally Retarded	T- Tewkesbury
C-14-21	H- Mentally Ill	C- Chelmsford
D-22-59	I- Elderly	W- Westford
E- 60 and over	J- Low Income	A- All Four Tow
	K- Youth	
	L- Other, Explain	

SERVICE CHARACTERISTICS

Direct Service Provided	#clients served per year	Age Group	Geo. Area (Check)	% of clients served from each town	Staff Alloc.
			B T W C A		
			B T W C A		
			B T W C A		
			B T W C A		
			B T W C A		
			B T W C A		
			B T W C A		
			B T W C A		
			B T W C A		
			B T W C A		
			B T W C A		
			B T W C A		

12. With what other agencies and for what purposes does your agency most frequently interact? Please use scale below to indicate the degree of interaction.

	PURPOSE OF INTERACTION									
AGENCY NAME	PLANNING	COORDINATION	FUNDING	CONTRACTS	INFORMATION & REFERRAL	PROFESSIONAL GROWTH TRAINING	REGULATION	TECHNICAL ASSISTANCE	STAFF SHARING	OTHER
Dept. of Public Welfare										
Mass. Commission for Blind										
Mass. Rehabilitation Comm.										
Merrimac Education Center										
Office for Children										
Solomon Mental Health										
Elder Services										
Division Youth Services										
OTHER AGENCIES (LIST)										

SCALE:
0-Never
1-Seldom(Monthly)
2-Average(Weekly)
3-Frequently(Daily)

13. What would you perceive as the major issues and constraints in the implementation of a human service center?

QUESTION #1 TOP FOUR SERVICE PRIORITIES OF A.S.P.T. AGENCIES

	SERVICES			
AGENCY	PRIORITY #I	PRIORITY #2	PRIORITY #3	PRIORITY #4
Council for Children	Prevention services for families	Intervention services for families	Adult support services	None
Solomon Mental Health Ctr.	Counseling (mental health)	Crisis intervention services	Psychiatric observation and assessment	Outreach and tracking
Dept. of Public Welfare (social services)	None	None	None	None
Dept. of Youth Services	Residential services	Detention services	Counseling	Employment related services
Elder Services of Merrimack Valley	In-home Services	Information & Referral	Advocacy	Community Education
Merrimack Education Ctr.	Diagnosis and Evaluation	Speech and Hearing	Medical Evaluation	Advocacy
Mass. Comm. for the Blind	Information and Referral	Counseling	Transportation	None
Mass. Rehab. Commission	Counseling	Employment Related Services	Physical Adaptation	Information and Referral

TABLE 5.2 QUESTION #2 HOW ARE THE PRIORITIES DETERMINED

AGENCY	RESPONSES
Council for Children	Consumer Needs
Solomon Mental Health Ctr.	Area Board, Regional Management, and Solomon Staff
Department Public Welfare	Consumer Needs
Elder Services of M/V	Board of Directors, Advisory Council, and Public Hearings
Merrimack Education Center	Special Education Administration
Mass. Commission for the Blind	Consumer Needs
Mass. Rehab. Commission	Agency Policy, Federal Mandate

TABLE 5.3 QUESTION #3 FUTURE CHANGE IN SERVICE PRIORITIES

AGENCY	RESPONSES
Council for Children	No
Solomon Mental Health	Day Services
Department Public Welfare	No
Dept. Youth Services	No
Elder Services	Increase Case Management, Advocacy, Transportation
Merrimack Education Ctr.	No
Mass. Comm. for the Blind	No
Mass. Rehab. Commission	Greater concentration in independent living.

TABLE 5.4 QUESTION #4 DIRECT SERVICE OFFICE IN AREA

AGENCY	RESPONSES
Council for Children	None
Solomon Mental Health Ctr.	Yes, Solomon Mental Health Center
Dept. Public Welfare	None (Only Assistance Payment Officers)
Dept. Youth Services	None
Elder Services	None
Merrimack Education Ctr.	Local Education Agencies
Mass. Comm. for Blind	None
Mass. Rehab. Commission	None

TABLE 5.5 QUESTION #5 STAFF ALLOCATION TO CENTER

AGENCY	ALLOCATION	
	NO. OF STAFF	TIME
Council for Children	None	
Solomon Mental Health	2 -3	5 day/week
Dept. Public Welfare	None	
Dept. Youth Services	None at present	
Elder Services	1	1/2 day/week
Merrimack Ed. Center	None at present, but 4-6 in FY-1980	
Mass. Comm. for Blind	1	1/2 day/week
Mass. Rehab. Comm.	2	2 day/week

TABLE 5.6 QUESTION #7 PRESENT FUNDING SOURCES

AGENCY	FUNDING
Council for Children	Title XX, and State Matching Funds (25%)
Solomon	State Funds (95%), NIMH Staffing Grant (5%)
Dept. Public Welfare	Federal and State Funding, Title XX
Dept. Youth Services	State appropriations (75%) Federal Grants, LEAA, Title I (23%) and donations (2%)
Elder Services	Title XX
Merrimack Education Ctr.	Local Taxes (90%), Special Ed/Fed. (10%)
Mass. Commission for Blind	Title XX, III, XVI, Section 110, Medicaid
Mass. Rehab. Commission	Title III, XVI/State Matching (20%). Section 110

TABLE 5.7 QUESTION #8 POSSIBLE FUTURE FUNDING SOURCES

AGENCY	FUNDING
Council for Children	No Future Funding Sources
Solomon	Dept. of Elder Services, NIMH Community Support Funds
Dept. Public Welfare	Federal Monies
Dept. Youth Services	State Appropriations, Federal Grants
Elder Services	Title XX, IX, III
Merrimack Ed. Center	Public Law 94-142, (766), Public Law 89-313) Occupational Education)
Mass. Comm. for Blind	No Future Funding Sources
Mass. Rehab. Commission	Innovation and Explanation Grants (Federal RSA Monies), Section 110, Residual Monies

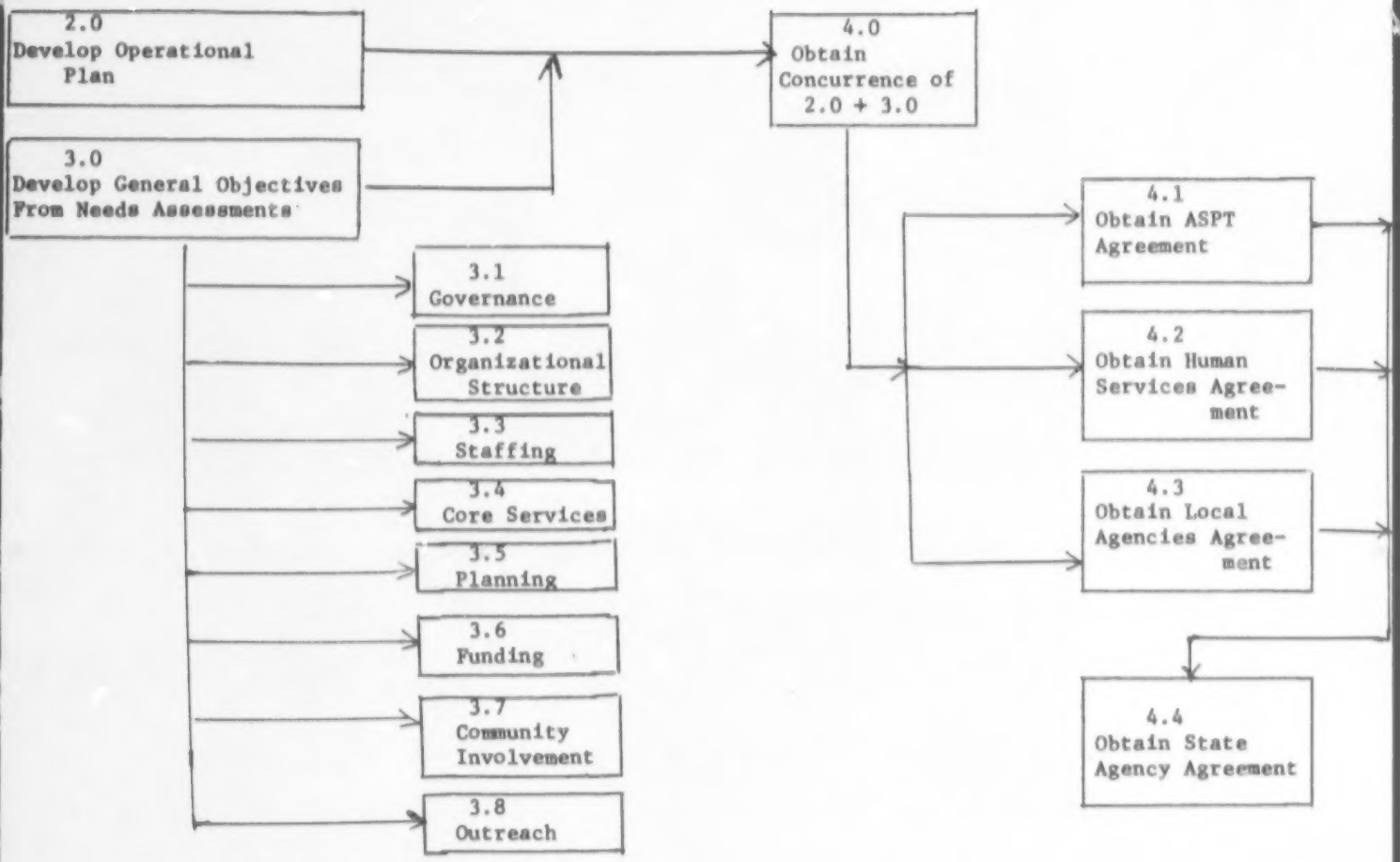
TABLE 5.8 QUESTION #9 PURCHASE OF SERVICES FROM OTHER AGENCIES

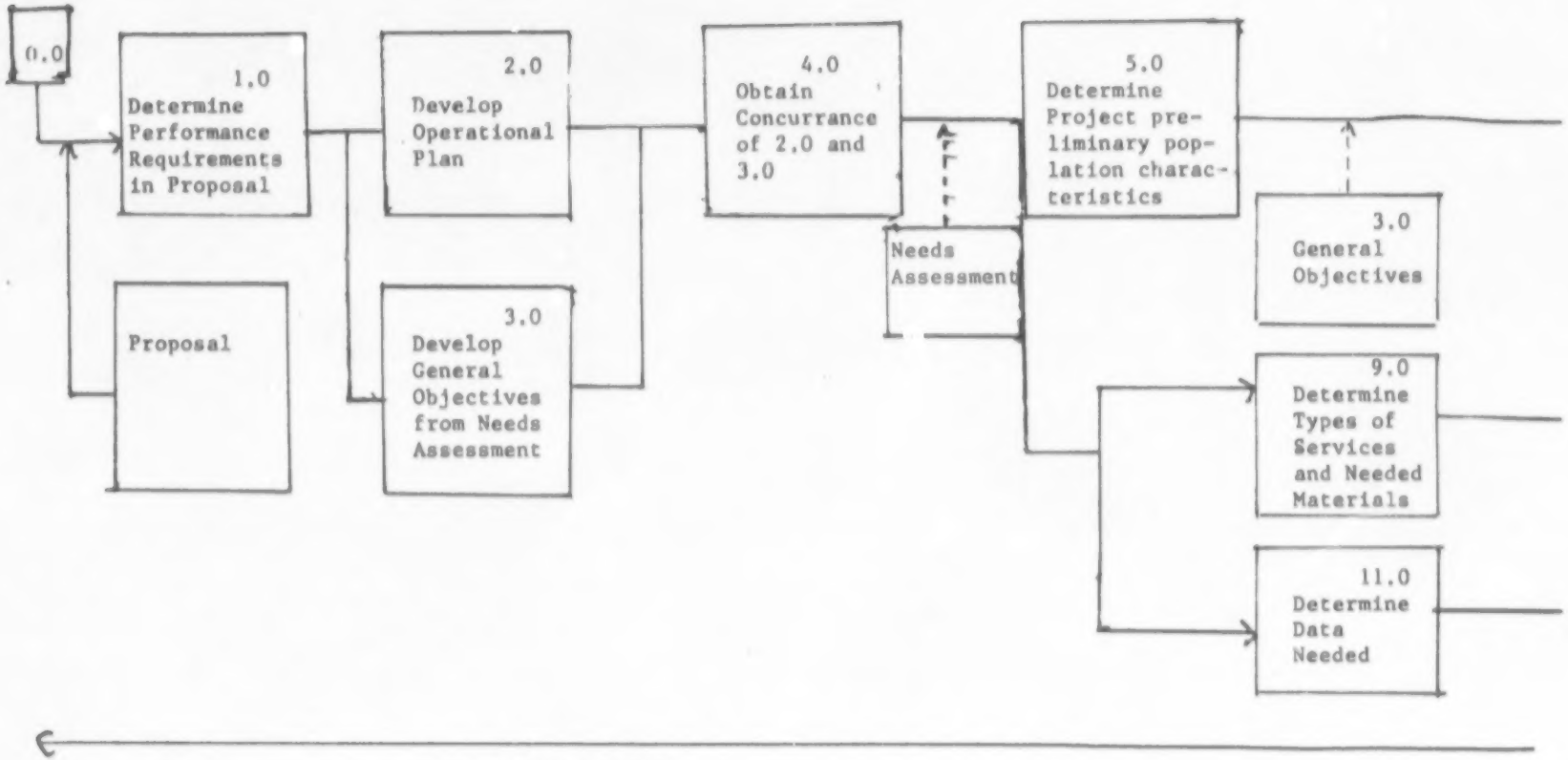
AGENCY	PURCHASES	
	SERVICE	AGENCY
. Council for Children	None	
Solomon	None	
Dept. Public Welfare	Yes, but did not describe type of services purchased	CIT(CAA Agency), Share, Lowell Nursery, Meadowbrook
Dept. Youth Services	Residential Counseling-tracking Counseling/Family Special Ed.	DARE, Inc. Key, Inc. Project Insight FARR Academy
Elder Services	Medical/Home care Transportation Protective Homemaker Chore Special Ed. Services	Lowell Visiting Nurse Service Local Taxi Service Solomon Mental Health Center Family Service Central Cleaning Collaboratives, and Private agencies
Mass. Comm. for Blind	Homemaker Transportation Training and Edication Medical	Family Service Local Taxi Services Carrol Center Lowell Visiting Nurse Service
Mass. Rehab. Commission	Evaluation and Training	Merrimack Valley Goodwill Rehab. Center

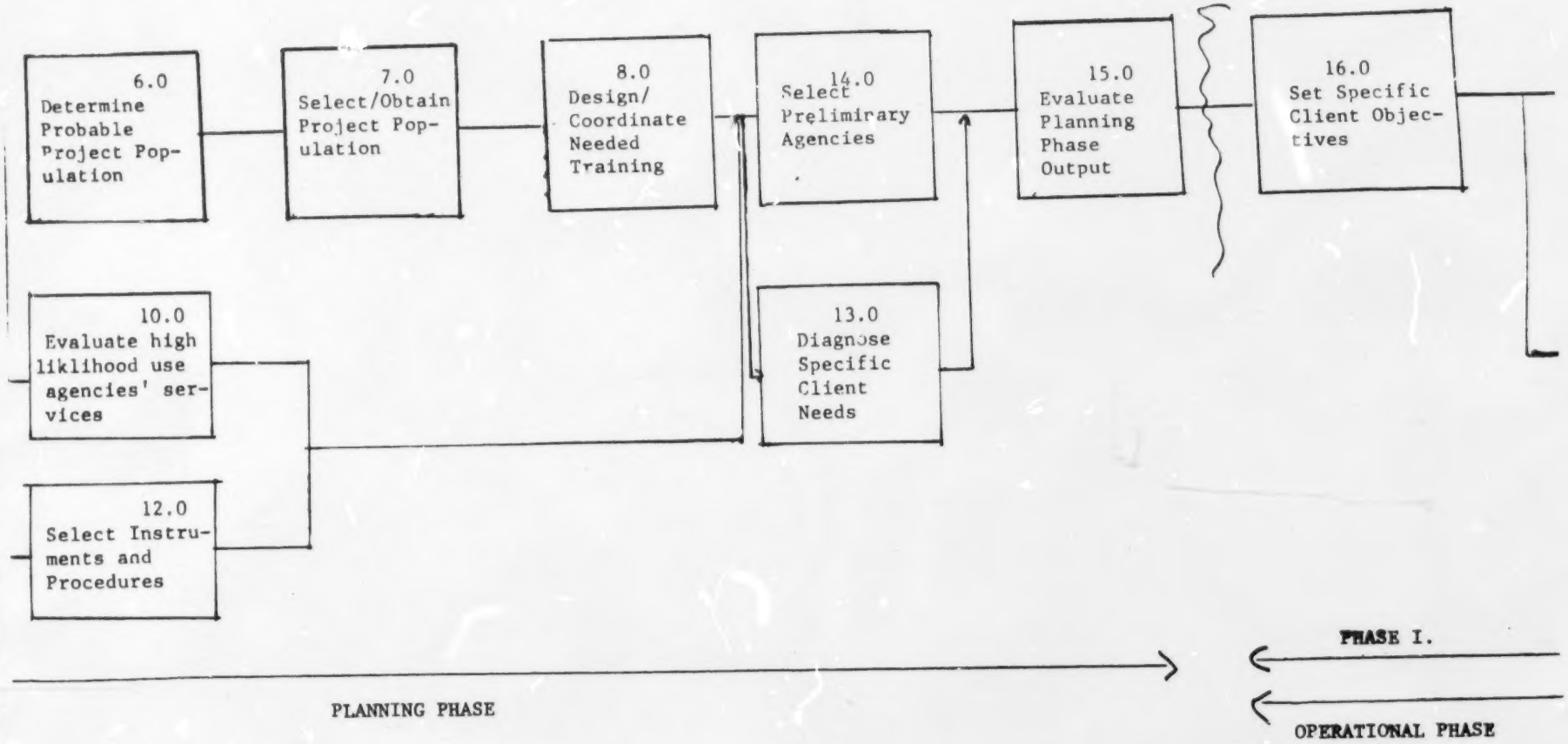
TABLE 5.9 QUESTION #13 ISSUE IN CENTER IMPLEMENTATION

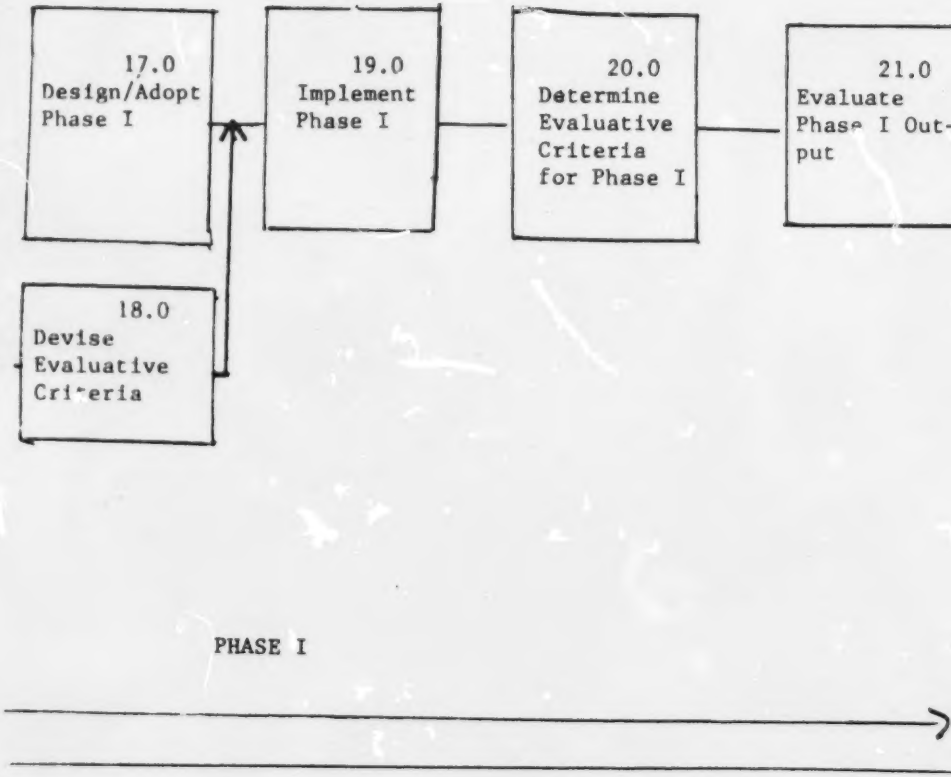
AGENCY	ISSUES
Council for Children	1. Lack of ASPT authority to make decisions regarding personnel/and funding re-allocation from agency to center 2. Over extension of agency staff as a result of time devoted to center 3. Evaluation of center effectiveness
Solomon	1. Staff allocation 2. Coordination of center with ASPT member agencies
Dept. Public Welfare	1. Duplication of services, between center and other agencies in the Lowell area.
Dept. Youth Services	1. Increase Bureacracy 2. Duplication of services 3. Evaluation of center effectiveness
Elder Services	1. Scheduling of Agency Staff 2. Communication to public/outreach 3. Coordination of center with ASPT member agencies 4. Stronger leadership 5. Agency Commitment to center
Merrimack Ed. Center	1. Coordination of center staff 2. Authority 3. Funding 4. Development of common intake/monitoring system 5. Evaluation 6. Agency regulations 7. Communications
Mass. Comm. for Blind	1. Commitment 2. Limited resources, personnel funding 3. Accessibility of center to handicapped individuals
Mass. Rehab. Commission	1. Cooperation between ASPT member agencies 2. Cross training of staff 3. Support from the Executive Office of Human Services

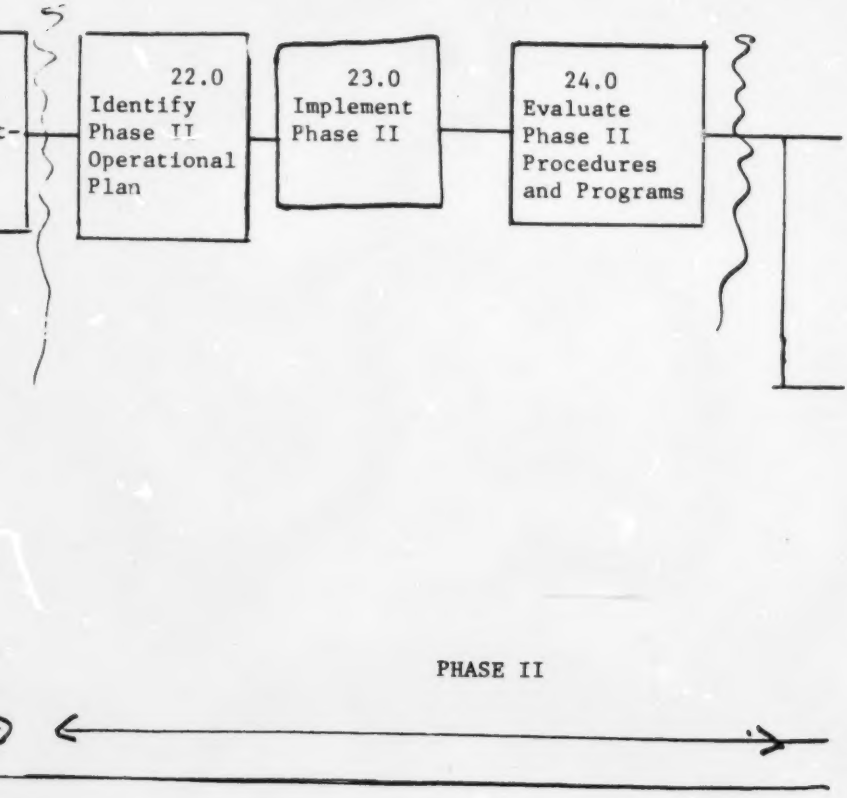
PLANNING PHASE



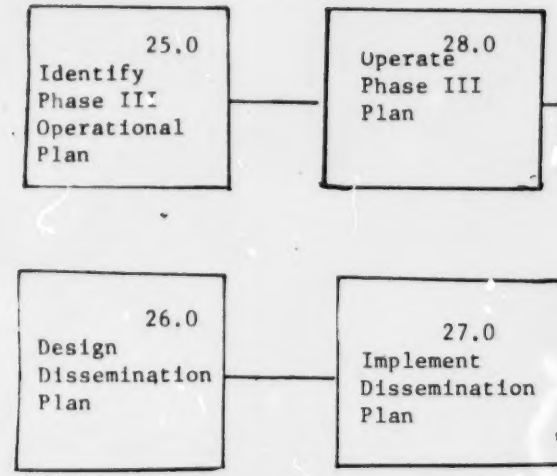

0.0
1.0
Determine Performance Requirements in Proposal
2.0
Develop Operational Plan
4.0
Obtain Concurrance of 2.0 and 3.0
5.0
Determine Project preliminary population characteristics
Needs Assessment
3.0
General Objectives
Proposal
3.0
Develop General Objectives from Needs Assessment
9.0
Determine Types of Services and Needed Materials
11.0
Determine Data Needed
PLANNING PHASE


6.0
Determine Probable Project Population
7.0
Select/Obtain Project Population
8.0
Design/ Coordinate Needed Training
14.0
Select Preliminary Agencies
15.0
Evaluate Planning Phase Output
16.0
Set Specific Client Objectives
10.0
Evaluate high liklihood use agencies' services
13.0
Diagnose Specific Client Needs
12.0
Select Instruments and Procedures
PHASE I.
PLANNING PHASE
OPERATIONAL PHASE

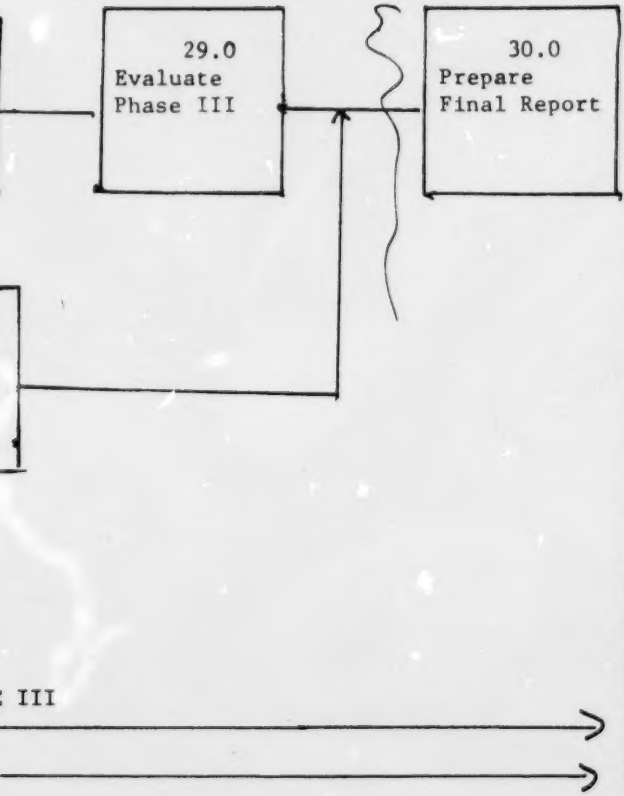

17.0
Design/Adopt
Phase I
19.0
Implement
Phase I
20.0
Determine
Evaluative
Criteria
for Phase I
21.0
Evaluate
Phase I Out-
put
18.0
Devise
Evaluative
Criteria
PHASE I
OPERATIONAL PHASE


22.0
Identify
Phase II
Operational
Plan
23.0
Implement
Phase II
24.0
Evaluate
Phase II
Procedures
and Programs

PHASE II



OPERATIONAL PHASES



III

Havelock [1] has suggested four primary ways in which individuals can act as change agents: as a catalyst, a solution giver, a process helper, or a resource linker. It seems obvious, in a historical sense, that the later mode, "resource linker," has had the most successful reign. One can look into the field of education in the Commonwealth of Massachusetts for examples of lasting organized collaboratives, such as the Merrimack Education Center and Project SPOKE, both of which have served as "linkers" of resources.

In the case of the Merrimack Education Center, it is obvious that this organization prefers to regard itself as performing the roles of process helper and resource linker.

These two roles are not mutually exclusive and indeed are complementary. Problem-solving studies are not solely at the "process" level. While the MEC assists people in moving toward a solution to a problem, it does not lead people to a place where there is no solution. The intention then is to link process to products and services utilizing change strategies of the "process helper" and "resource linker."

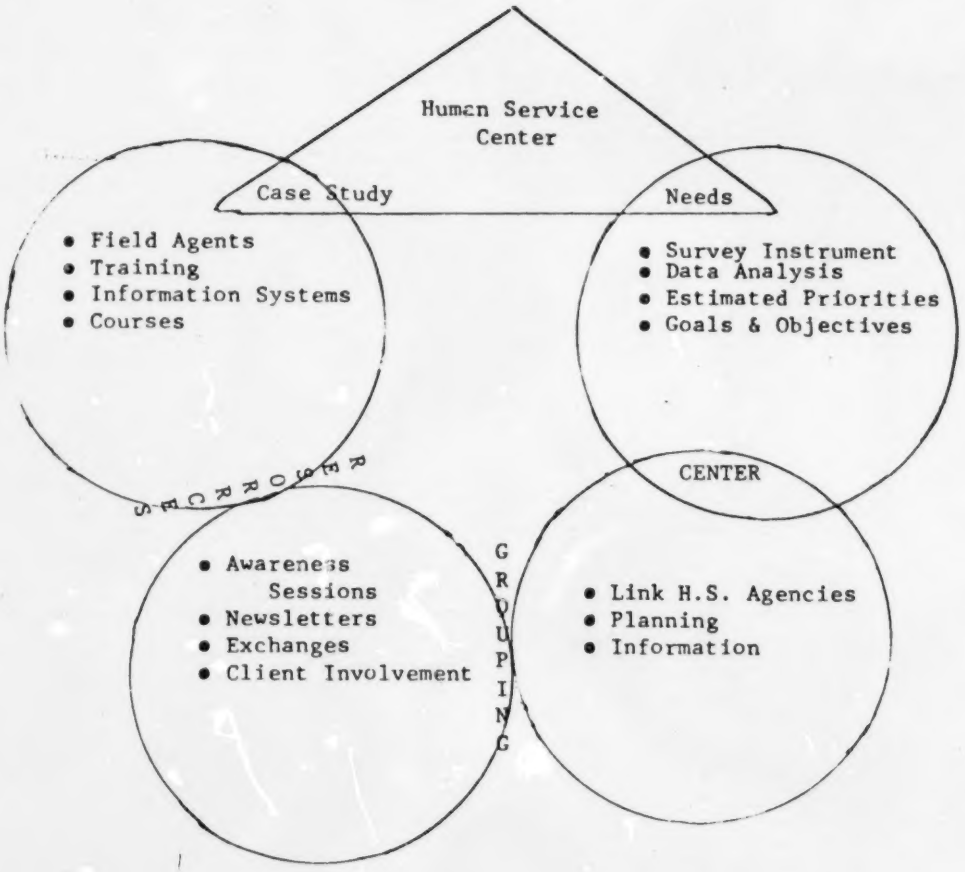
MEC staff play these roles in the overall planning and installation of innovations. Activities are comprised of the six problem-solving stages:

1. Building a relationship,
2. Diagnosing the problem,
3. Acquiring relevant resources,
4. Choosing the solution,
5. Gaining acceptance, and
6. Stabilizing the innovation.

Although this process may be undertaken for change projects of any scale, from system-wide reorganization of an agency to the introduction of specific materials or procedures in delivery, the major thrust is at the system level.

It is recommended, therefore, that this same type of approach be utilized in the formation of the multi-service center, as described in the B. C. study.

If one were to model this Center, it would probably appear as below:



[1] Havelock, R. G. The Change Agent's Guide to Innovation in Education, Englewood Cliffs, New Jersey: Educational Technology Pubications, 1973

SUGGESTED STRATEGIES AND TACTICS

1. Build and maintain awareness of the resource universe.

2. Acquire resources for seven major purposes:

    a. Diagnosis
    b. Awareness
    c. Evaluation-before-trial
    d. Trial
    e. Evaluation-after-trial
    f. Installation
    g. Maintenance

3. Homing in on a specific problem and/or solution:

    a. Obtain written overview
    b. Overview from knowledgeable person
    c. Observe "live" examples
    d. Obtain evaluation data
    e. Obtain innovation on trial
    f. Acquire a framework for evaluation after trial

4. Build a permanent capacity for resource acquisition:

    a. Supportive atmosphere
    b. Maintain interactions
    c. Use creative practitioners
    d. Use in-house experts
    e. Generate realistic expectations about information
    f. Assess impact of past experience with resource retrieval on present client attitudes
    g. Demonstrate value of resources
    h. Structure acquisition
    i. Teach clients to structure acquisition
    j. Localize resources

	PHASE I
Core Services	
-- Intake	-- Common Intake -- Filing cabinet system of record storage -- System analyst works on MIS
-- Diagnosis	-- Case Team-referral by Intake/Receptionist
Referral	-- All made by Broker -- Contractual arrangements -- LASPT Agencies provide mandated services
Monitoring	----- Agencies appoint their own case managers
Follow-up	-- Broker interviews client -- Continues service -- Contracts service agency
Billing	-- Broker authorizes billing

PHASE II	PHASE III
-- Add screening person -- MIS in place	-- Same
-- Meeting frequency increased as necessary	-- Addition of evaluations & diagnosis -- Add medical diagnosis
-- Still made by Broker with assistance from MIS	-- Same
-- Same	-- Same
-- Same	-- Same
-- Addition of indirect service billing	-- Center becomes Fiscal Agent

ELEMENT	PHASE I	PHASE II	PHASE III
Grievance	ASPT assumes role of grievance Recruitment for consumers, local officials	Recruitment and appointment of (8) consumers, (8) local officials Task force organized around issues	Recruitment from task forces
Organiz. Structure	Collegial Model, contracts designed to give authority to systems manager. Core staff-direct line authority	On going →	
Staff Pattern	Core Staff: Systems Manager, Broker, Intake/Receptionist Direct Service Staff Solomon 2-3 full time MRC 2 part time MCB 1 part time Elder 1/2 part time MEC As needed Systems Analyst Consultant for MIS	More direct service staff Solomon 6-8 full time	Core staff: addition of Broker On-site location of agency supervisors

MATRIX OF CENTER PHASES

ELEMENT	PHASE I	PHASE II	PHASE III
Programming and Planning 1. Identify needs 2. Identify gaps 3. Report to Governance 4. Agency designation 5. Technical assistance of systems manager	ASPT as governance determine priorities	MIS Case conference Broker Evaluation	Addition of Task Forces
Funding	seed money search for grants, etc.	-- grants (federal, State, and private foundations) -- pooled resources -- billing system in place for two agencies generates funds for center	-- center becomes fiscal agent for all agencies -- pooled resources -- grants
Evaluation	-- develop system that measures client usage and satisfaction. -- develop system that measures how well the center integrates services and its effectiveness	on going →	